



Washington State Health Care Authority		CONTRACT AMENDMENT		HCA Contract Number: K893 Amendment No.: 01 Contractor/Vendor Contract Number:	
THIS AMENDMENT is between the Washington State Health Care Authority, hereinafter referred to as "HCA," and the party whose name appears below, hereinafter referred to as the "Contractor."					
UNILATERAL AMENDMENT: <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO The Contract is herein, including any previous amendments hereto, is hereby unilaterally amended as set forth on page two (2) pursuant to the changes and modifications section as contained therein.					
CONTRACTOR NAME United Behavioral Health		CONTRACTOR doing business as (DBA)			
CONTRACTOR ADDRESS 3315 S Twenty-Third, Suite 310 Tacoma, Washington 98405		FEDERAL EMPLOYER IDENTIFICATION NUMBER (EIN) 94-2649097		STATEWIDE VENDOR NUMBER (SWV) SWV0041511-00	
CONTRACTOR CONTACT Cheri Dolezal		CONTRACTOR TELEPHONE (253) 292-4183		CONTRACTOR E-MAIL ADDRESS cheri.dolezal@optum.com	
HCA PROGRAM TITLE Health Homes		HCA DIVISION/SECTION Health Care Services/Grants & Program Development		HCA CONTRACT CODE HCS-GPD-III	
HCA CONTACT NAME AND TITLE Becky McAninch-Dake, Program Manager		HCA CONTACT ADDRESS Cherry Street Plaza, Second Floor 626 Eighth Avenue SE P.O. Box # 45530 Olympia, WA 98504-5530			
HCA CONTACT TELEPHONE 360.725.1642		HCA CONTACT E-MAIL ADDRESS becky.mcaininch-dake@hca.wa.gov			
IS THE CONTRACTOR A SUBRECIPIENT FOR PURPOSES OF THIS CONTRACT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		CFDA NUMBER(S) 93.778		FFATA Form Required <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
AMENDMENT START DATE June 30, 2014		AMENDMENT END DATE June 30, 2016		CONTRACT END DATE June 30, 2016	
PRIOR MAXIMUM CONTRACT AMOUNT No Maximum Amount		AMOUNT OF INCREASE OR DECREASE No Change in Amount		TOTAL MAXIMUM CONTRACT AMOUNT No Maximum Amount NON- FINANCIAL <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
REASON FOR AMENDMENT: CHANGE or CORRECT: Period of Performance Contract Terms and Conditions					
ATTACHMENTS/EXHIBITS/SCHEDULES: When the box below is marked with an X, the following Exhibits/Attachments are attached and are incorporated into this Contract Amendment by reference: <input checked="" type="checkbox"/> Attachment(s) (specify): Attachment 1: HCA Contract # K893 (Replacement Document) <input type="checkbox"/> Exhibit(s) (specify): <input type="checkbox"/> Schedule(s) (specify): <input type="checkbox"/> No Exhibit/Attachment					
This Contract Amendment, including all Exhibits and other documents incorporated by reference, contains all of the terms and conditions agreed upon by the parties as changes to the original Contract. No other understandings or representations, oral or otherwise, regarding the subject matter of this Contract Amendment shall be deemed to exist or bind the parties. All other terms and conditions of the original Contract remain in full force and effect. The parties signing below warrant that they have read and understand this Contract Amendment, and have authority to enter into this Contract Amendment.					
CONTRACTOR SIGNATURE 		PRINTED NAME AND TITLE LESLIE J. DAVIS, CFO		DATE SIGNED 7/6/14	
HCA SIGNATURE 		PRINTED NAME AND TITLE Annette Schuffenhauer, CFO		DATE SIGNED 7/11/14	

This Contract between the State of Washington Health Care Authority (HCA) and the Contractor is hereby amended as follows:

1. AMENDMENT PURPOSE

The purpose of this amendment is to replace the existing contract in its entirety with the document attached to this Amendment as Attachment 1 that includes these substantive changes that shall be effective as of the Amendment State Date as stated on Page One of this Amendment:

- The Contract End Date stated on Page One of the Contract is extended from June 30, 2015 to June 30, 2016.
- The Modified Gregg Numbering Style used in the original contract has been replaced with the Legal Numbering Style.
- A Table of Contents has been added.
- The General Terms and Conditions sections that apply to all contracts have been grouped under the heading of General Terms and Conditions. The remaining General Terms and Conditions sections have been relocated under the heading to which they apply.
- The three Definition sections in Exhibit C are now separate sections in the main Contract.
- Contractor Program Integrity Requirements are in Section 8.
- Revised PRISM access requirements for Designated Staff are included in Sections 9.2.3 and 9.6.
- Revised Payment Tiers for Contractors included in Section 10 are revised.
 - The description of Intensive Health Homes Care Coordination in Section 10.4.2 is revised.
 - The description of Low Level Health Homes Care Coordination in Section 10.4.3 is revised.
- Contractor Participation Rate requirements for incentive payments in Section 10.5. are revised.
- Contractor Requirements for Grievance Procedures are added as Section 11.
- Contractor Policies and Procedures Requirements are consolidated into Subsection 12.3.
- Modified Contractor Requirements for Written Beneficiary Material are included in Section 12.4 to make them consistent with Apple Health requirements.
- Contractor Requirement for Training is added as Section 12.5.
- Contractor Health Action Plans Requirements are consolidated into Subsection 12.9.
- Contractor Reporting Requirements are expanded and moved to subsection 12.16.
- Contractor Requirement for annual submission of list of CCOs is added as Section 12.16.4.
- Contractor Requirement for Incident Reporting is added as Section 12.16.5.

2. AMENDMENT SECTION

The entire contract document executed on **October 1, 2013** is struck and being replaced with the contract document attached as Attachment 1.

All other terms and conditions of this Contract remain in full force and effect.


		CLIENT SERVICES CONTRACT Qualified Health Home Coverage Area 1		HCA CONTRACT NUMBER: K893 ECMS REFERENCE NUMBER:	
This Contract is by and between the State of Washington Health Care Authority ("HCA") and the Contractor identified below					Contractor Contract Number:
CONTRACTOR NAME: United Behavioral Health			CONTRACTOR doing business as (DBA):		
CONTRACTOR ADDRESS: 3315 S Twenty-Third, Suite 310 Tacoma, Washington 98405			CONTRACTOR FEDERAL EMPLOYER IDENTIFICATION NUMBER: 94-2649097		
CONTRACTOR CONTACT: Cheri Dolezal		CONTRACTOR TELEPHONE: (253) 292-4183		CONTRACTOR E-MAIL ADDRESS: cheri.dolezal@optum.com	
HCA PROGRAM AREA: Health Home			HCA DIVISION/HCA SECTION: Health Care Services/Grants and Program Development		
HCA CONTACT NAME AND TITLE: Becky McAninch-Dake Health Home Program Manager		HCA CONTACT ADDRESS: Grants and Program Development Section Cherry Street Plaza Second Floor 626 Eighth Avenue SE Olympia, Washington 98504-5530			
HCA CONTACT TELEPHONE: (360) 725-1642			HCA CONTACT E-MAIL ADDRESS: becky.mcaninch-dake@hca.wa.gov		
IS THE CONTRACTOR A SUB-RECIPIENT FOR PURPOSES OF THIS CONTRACT? NO				CFDA NUMBER(S): 93.778	
CONTRACT START DATE: October 1, 2013		CONTRACT END DATE: June 30, 2016		MAXIMUM CONTRACT AMOUNT: No Maximum Amount	
EXHIBITS, ATTACHMENTS, and SCHEDULES. The following Exhibits, Attachments, and Schedules are attached and are incorporated into this Contract by reference:					
<input checked="" type="checkbox"/> Exhibits (specify): Exhibit A: Nondisclosure of HCA Confidential Information; Exhibit B: Federal Compliance, Certifications and Assurances					
<input checked="" type="checkbox"/> Attachments (specify): Attachment A: Part D WA State Data Use Agreement; Attachment B: Supplement to Data Use Agreement; Attachment C: Conflict of Interest; Attachment D: WA State Information Exchange Agreement; Attachment E: WA Coordination of Benefits and Quality Improvement Approval					
<input type="checkbox"/> Schedules (specify):					
<input type="checkbox"/> No Exhibits.					
The terms and conditions of this Contract are an integration and representation of the final, entire and exclusive understanding between the parties superseding and merging all previous agreements, writings, and communications, oral or otherwise regarding the subject matter of this Contract, between the parties. The parties signing below represent they have read and understand this Contract, and have the authority to execute this Contract. This Contract shall be binding on HCA only upon signature by HCA.					
CONTRACTOR SIGNATURE: SIGNATURE NOT REQUIRED		PRINTED NAME AND TITLE:		DATE SIGNED:	
HCA SIGNATURE: SIGNATURE NOT REQUIRED		PRINTED NAME AND TITLE: Laura Wood, Contracts Administrator		DATE SIGNED:	

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1. PURPOSE OF AGREEMENT

The purpose of this Contract is to implement a community based Health Home program in accordance with the requirements of Section 2703 of the Patient Protection and Affordable Care Act of 2010 utilizing the Managed Fee-for-Service (FFS) Demonstration model, Washington State Substitute Senate Bill 5394 and the Contractor's response to the Health Care Authority's RFA No. 12-005. The Contractor shall provide intensive Health Home care coordination services to high-cost, high-need Medicaid and Medicaid/Medicare beneficiaries to ensure that services delivered are integrated and coordinated across medical, mental health, chemical dependency and long term services and supports.

2. PERIOD OF PERFORMANCE

Subject to its other provisions, the period of performance of this Contract shall commence on October 1, 2013, and be completed on June 30, 2016 unless terminated sooner or extended, as provided herein.

3. CONTRACT MANAGEMENT

Unless otherwise specified in this Contract, the individuals identified on page one (1) of this Contract are the contacts for all Notices required or permitted under this Contract. Either party may change its Contact from time to time by providing written notice in accordance with Section 7.17, Notices.

4. GENERAL DEFINITIONS

- 4.1. **"Agent"** means the Washington State Health Care Authority Director and/or the Director's delegate authorized in writing to act on behalf of the Director.
- 4.2. **"Centers for Medicare & Medicaid Services (CMS)"** is the federal agency within the United States Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.
- 4.3. **"Client"** or **"HCA Client"** means an applicant, recipient, or former applicant or recipient of any service of program administered by HCA.
- 4.4. **"Code of Federal Regulations (CFR)"** is the codification of the general and permanent rules and regulations (sometimes called administrative law) published in the Federal Register by the executive departments and agencies of the federal government of the United States.
- 4.5. **"Contract"** means the entire written agreement between HCA and the Contractor, including any Exhibits, attachments, documents, or materials incorporated by reference. The parties may execute this Contract in multiple counterparts, each of which is deemed an original and all of which constitutes as one agreement. E-mail (electronic mail) or fax (facsimile) transmission of a signed copy of this Contract shall be the same as delivery of an original.

- 4.6. **"Contractor"** means the individual or entity performing services pursuant to this Contract and includes the Contractor's owners, members, officers, directors, partners, employees and/or agents, unless otherwise stated in this Contract. For purposes of any permitted Subcontract, "Contractor" includes any Subcontractor and its owners, members, officers, directors, partners, employees and/or agents.
- 4.7. **"Debarment"** means an action taken by a Federal agency or official to exclude a person or business entity from participating in transactions involving certain federal funds.
- 4.8. **"Department of Social and Health Services (DSHS)"** is the state agency responsible for providing a broad array of healthcare and social services.
- 4.9. **"HCA"** means the Washington State Health Care Authority, any division, section, office, unit or other entity thereof, or any of the officers or other officials lawfully representing the Authority.
- 4.10. **"HCA Acquisition and Risk Management Services"** is the Washington State Health Care Authority central headquarters contracting office, or successor section or office.
- 4.11. **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, the federal legislation that protects health insurance coverage for workers and their families when they change or lose their jobs, and requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers.
- 4.12. **"Managed Care Organization (MCO)"** is an organization having a certificate of authority or certificate of registration from the Washington State Office of the Insurance Commissioner which contracts with the State under a comprehensive risk contract to provide prepaid health care services to eligible beneficiaries under managed care programs.
- 4.13. **"Medicaid"** means the programs of medical assistance benefits under Title XIX of the Social Security Act and various Demonstrations and Waivers thereof.
- 4.14. **"Memorandum of Understanding (MOU)"** is a business agreement for partnerships that do not involve a financial arrangement that describe the roles and responsibilities of each party to the agreement.
- 4.15. **"OMB"** is the Office of Management and Budget of the Executive Office of the President of the United States.
- 4.16. **"Patient Protection and Affordable Care Acts"** means Public Laws 111-148 and 111-152 (both enacted in March 2010). The law includes multiple provisions that are scheduled to take effect over a matter of years, including the expansion of Medicaid eligibility, the establishment of health insurance exchanges and prohibiting health insurers from denying coverage due to pre-existing conditions.
- 4.17. **"ProviderOne"** is the Health Care Authority's encounter reporting and payment processing system.

- 4.18. **"RCW"** is the Revised Code of Washington. All references in this Contract to RCW chapters or sections shall include any successor, amended, or replacement statute. Pertinent RCW chapters can be accessed at: <http://apps.leg.wa.gov/rcw/>.
- 4.19. **"Regional Support Network (RSN)"** means a county authority or group of county authorities or other entity recognized by the secretary of the Department of Social and Health Services to administer mental health services in a defined region. RSNs are specialty behavioral health plans operating under 1915(b) Medicaid authority.
- 4.20. **"Regulation"** means any federal, state, or local regulation, rule, or ordinance.
- 4.21. **"Subcontract"** means any separate agreement or contract between the Contractor and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations that the Contractor is obligated to perform pursuant to this Contract.
- 4.22. **"Successor"** means any entity which, through amalgamation, consolidation, or other legal succession becomes invested with rights and assumes burdens of the original Contractor.
- 4.23. **"Sub-recipient"** means a non-Federal entity that expends federal awards received from a pass-through entity to carry out a federal program, but does not include an individual that is a Beneficiary of such a program. A sub-recipient may also be a recipient of other Federal awards directly from a federal awarding agency. See OMB Circular A-133 for additional details.
- 4.24. **"Vendor"** means a dealer, distributor, merchant, or other seller providing goods or services that are required for the conduct of a federal program. These goods or services may be for an organization's own use or for the use of beneficiaries of the federal program. See OMB Circular A-133 for additional details.
- 4.25. **"Vulnerable Adult"** includes a person:
- 4.25.1. Sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself;
 - 4.25.2. Found incapacitated under Chapter 11.88 RCW;
 - 4.25.3. Who has a developmental disability as defined under RCW 71A.10.020; or
 - 4.25.4. Admitted to any facility;
 - 4.25.5. Receiving services from home health, hospice, or home care agencies licensed or required to be licensed under Chapter 70.127 RCW;
 - 4.25.6. Receiving services from an individual care provider; or
 - 4.25.7. Who directs his or her own care and receives services from a personal aide under Chapter 74.39 RCW.
- 4.26. **"WAC"** is the Washington Administrative Code. All references in this Contract to WAC chapters or sections shall include any successor, amended, or replacement

regulation. Pertinent WAC chapters or sections can be accessed at:
<http://apps.leg.wa.gov/wac/>.

5. DATA SECURITY DEFINITIONS

- 5.1. **"Authorized User(s)"** means an individual or individuals with an authorized business requirement to access HCA Confidential Information.
- 5.2. **"Confidential Information"** means information that is exempt from disclosure to the public or other unauthorized persons under Chapter 42.56 RCW or other federal or state laws. Confidential Information includes, but is not limited to, Personal Health Information.
- 5.3. **"Data"** means information that is disclosed or exchanged as described in this Contract.
- 5.4. **"Data Access"** refers to rights granted to Designated Staff to view and use Data for the purposes expressly authorized by this Contract.
- 5.5. **"Data Encryption"** refers to ciphers, algorithms or other mechanisms that will encode data to protect its confidentiality. Data encryption can be required during data transmission or data storage depending on the level of protection required.
- 5.6. **"Data Storage"** refers to the state data is in when at rest. Data can be stored on off-line devices such as CD's or on-line on Contractor servers or Contractor employee workstations.
- 5.7. **"Data Transmission"** refers to the methods and technologies to be used to move a copy of the data between HCA and Contractor systems, networks and/or employee workstations.
- 5.8. **"Designated Staff"** means either the Contractor's employee(s) or employee of any Subcontractor that has been delegated authority to provide Health Home Services and who is authorized by their employer to access Data.
- 5.9. **"Encrypt"** means to encode Confidential Information into a format that can only be read by those possessing a "key"; a password, digital certificate or other mechanism available only to authorized users. Encryption must use a key length of at least 128 bits.
- 5.10. **"Hardened Password"** means a string of at least eight characters containing at least one alphabetic character, at least one number and at least one special character such as an asterisk, ampersand or exclamation point.
- 5.11. **"Personal Information"** means information identifiable to any person, including, but not limited to, information that relates to a person's name, health, finances, education, business, use or receipt of governmental services or other activities, addresses, telephone numbers, Social Security Numbers, driver license numbers, other identifying numbers and any financial identifiers.
- 5.12. **"Physically Secure"** means that access is restricted through physical means to authorized individuals only.

- 5.13. **"Predictive Risk Intelligence System (PRISM)"** means the joint DSHS/HCA, DSHS Research and Data Analysis administered, web-based database used for predictive modeling and clinical decision support and is refreshed on a weekly basis. PRISM provides prospective medical risk scores that are a measure of expected costs in the next 12 months based on the Beneficiary's disease profiles and pharmacy utilization. PRISM identifies beneficiaries in most need of comprehensive care coordination based on risk scores; integrates information from primary, acute, social services, behavioral health, and long term care payment and assessment data systems; and displays health and demographic information from administrative data sources.
- 5.14. **"Protected Health Information"** means Individually Identifiable Health Information;
- 5.15. **"Public Information"** means information that can be released to the public. It does not need protection from unauthorized disclosure, but does need protection from unauthorized change that may mislead the public or embarrass HCA.
- 5.16. **"RDA" or "Research and Data Analysis"** means the division of DSHS that supports analyses of client counts, caseloads, expenditures and use rates within and between DSHS services and programs
- 5.17. **"Secured Area"** means an area to which only authorized representatives of the entity possessing the Confidential Information have access. Secured Areas may include buildings, rooms or locked storage containers (such as a filing cabinet) within a room, as long as access to the Confidential Information is not available to unauthorized personnel.
- 5.18. **"Sensitive Information"** means information that is not specifically protected by law, but should be limited to official use only, and protected against unauthorized access.
- 5.19. **"Tracking"** means a record keeping system that identifies when the sender begins delivery of Confidential Information to the authorized and intended recipient, and when the sender receives confirmation of delivery from the authorized and intended recipient of Confidential Information.
- 5.20. **"Trusted Systems"** includes:
- 5.20.1. For physical delivery only the following methods:
 - 5.20.1.1. Hand-delivery by a person authorized to have access to the Confidential Information with written acknowledgement of receipt;
 - 5.20.1.2. United States Postal Service (USPS) first class mail, or USPS delivery services that include Tracking, such as Certified Mail, Express Mail or Registered Mail;
 - 5.20.1.3. Commercial delivery services (e.g. FedEx, UPS, DHL) which offer tracking and receipt confirmation; and
 - 5.20.1.4. The Washington State Campus mail system;

- 5.20.2. For electronic transmission, the Washington State Governmental Network (SGN) is a Trusted System for communications within that Network.

6. HEALTH HOME DEFINITIONS

- 6.1. **"Action"** is the denial or limited authorization by the Contractor of a request health home service, including the type or level of health home service; the reduction, suspension, or termination by the Contractor of a previously authorized health home service; and the failure of the Contractor to provide authorized health home services or provide health home services in a timely manner.
- 6.2. **"Area Agency on Aging (AAA)"** is a local agency that uses state and federal resources to help older persons and adults with disabilities live in their own homes and communities as long as possible, postponing or eliminating the need for residential or institutional care (such as nursing homes). AAA's were created under the Older Americans Act of 1965.
- 6.3. **"Authorizing Entity"** is an organization contracted by the State to approve or disapprove covered benefits for Medicaid beneficiaries following utilization guidelines. Examples include but are not limited to Managed Care Organizations, Regional Support Networks, Home and Community Based Services Providers.
- 6.4. **"Behavioral Health Services"** means services that address the promotion of emotional health; the prevention of mental illness and substance use disorders; and the treatment of substance abuse, addiction, substance use disorders, mental illness, and/or mental disorders.
- 6.5. **"Beneficiary"** means a Client who is eligible for Health Home Services based upon at least one chronic condition and being at risk of a second as determined by a predictive PRISM risk score of 1.5.
- 6.6. **"Caregiver Activation Measure (CAM)"** means, an assessment that gauges the knowledge, skills and confidence essential to providing care for a person with chronic conditions. The CAM assessment segments caregivers into one of four progressively higher activation levels. Each level addresses a broad array of behaviors and offers deep insight into the characteristics.
- 6.7. **"Chronic Condition"** is a physical or behavioral health condition that is persistent or otherwise long lasting in its effects.
- 6.8. **"Clinical Eligibility Tool"** is the referral tool used to determine if the potential Health Home Beneficiary is eligible for Health Home services by manually calculating their risk score based upon diagnosis.
- 6.9. **"Comprehensive Assessment Report and Evaluation (CARE)"** is a person centered, automated assessment tool used for determining Medicaid functional eligibility, level of care for budget and comprehensive care planning, as defined in WAC 388-106 or any successor provisions thereto.
- 6.10. **"Coverage Area(s)"** means pre-determined geographical areas composed of specific counties developed to manage a phased-in implementation of Health Homes.

- 6.11. **"Covered Services"** means the set of Medicare and Medicaid services that will be coordinated as part of the Health Home program.
- 6.12. **"Developmental Disabilities Administration (DDA)"** is the administration within the Department of Social and Health Services that provides services to individuals with developmental disabilities who are functionally and financially determined to receive such services.
- 6.13. **"Fee-for-Service (FFS)"** means the Medicaid delivery system that provides covered Medicaid benefits to eligible beneficiaries through any willing and contracted provider. Payment is made on a per service basis.
- 6.14. **"Hallmark Events"** means elevated episodes of care that have potential to seriously affect the Beneficiary's health or health outcomes.
- 6.15. **"Health Action Plan (HAP)"** is a Beneficiary prioritized plan identifying what the beneficiary and others plan to do to improve his or her health.
- 6.16. **"Health Home Care Coordination"** means an approach to healthcare in which all of a Beneficiary's needs are coordinated with the assistance of a primary point of contact. The point of contact provides information to the Beneficiary and the Beneficiary's caregivers, and works with the Beneficiary to make sure that the Beneficiary gets the most appropriate treatment, while ensuring that health care is not accidentally duplicated.
- 6.17. **"Health Home Care Coordination Assignment"** means the process used to determine which Health Home Care Coordination Organization is responsible for delivering the six Health Home care coordination services to the Beneficiary.
- 6.18. **"Health Home Care Coordination Organization" or "CCO"** means an organization within the Qualified Health Home network that is responsible for delivering the six (6) Health Home services to the Participant.
- 6.19. **"Health Home Care Coordinator"** means staff employed by the Contractor or a Health Home Care Coordination Organization to provide the six (6) pre-defined Health Home care coordination services. Services must be provided through face to face, telephonic and electronic contact by registered nurses, advanced registered nurse practitioners, licensed practical nurses, psychiatric nurses, psychiatrists, physician's assistants, clinical psychologists, licensed mental health counselors, agency affiliated certified mental health counselors, licensed marriage and family therapists, MSW, BSW or related Bachelor's prepared social workers, and certified chemical dependency professionals.
- 6.20. **"Health Home Information Sharing Consent Form"** means a release form signed by the Beneficiary to authorize the release of information to facilitate the sharing of the Beneficiary's health information.
- 6.21. **"Health Home Enrollment"** means the process used to place Health Home eligible beneficiaries into a Qualified Health Home.
- 6.22. **"Health Home Provider Business Associate (HHPBA)"** means, a Health Home

Provider with whom HCA has a Business Associate Agreement.

- 6.23. **"Health Home Services"** means a group of six (6) intensive services that coordinate care across several domains, as defined under Section 2703 of the Affordable Care Act of 2010 to coordinate the full breadth of clinical and social service expertise for high cost/high risk beneficiaries with complex chronic conditions, mental health and substance use disorder issues and/or long term service needs and supports. The six services are:
- 6.23.1. Comprehensive care management;
 - 6.23.2. Care coordination and health promotion;
 - 6.23.3. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
 - 6.23.4. Individual and family support, which includes authorized representatives;
 - 6.23.5. Referral to community and social support services, if relevant;
 - 6.23.6. The use of health information technology to link services, as feasible and appropriate.
- 6.24. **"Long Term Services and Supports (LTSS)"** means the variety of services and supports that help people with functional impairments meet their daily needs for assistance in community based settings and improve the quality of their lives. Examples include: Personal care assistance with daily activities such as bathing, dressing and personal hygiene in in-home and licensed community residential settings, home delivered meals, personal emergency response systems, adult day services, environmental modifications and other services designed to divert individuals from nursing facility care. LTSS also includes services provided in licensed nursing facilities. LTSS are provided either in short periods of time when recovering from an injury or acute health episode or over an extended period.
- 6.25. **"Multidisciplinary Teams"** are groups of allied health care staff, such as community health workers, peer counselors or other non-clinical staff that facilitates the work of the Health Home Care Coordinator. Additional members of the Multidisciplinary Teams can be primary care providers, mental health professionals, chemical dependency treatment providers, and social workers. Optional team members may include nutritionists/dieticians, direct care workers, pharmacists, peer specialists, family members or housing representatives.
- 6.26. **"Patient Activation Measure (PAM)"** is an assessment that gauges the knowledge, skills and confidence essential to managing one's own health and healthcare. The PAM assessment segments consumers into one of four progressively higher activation levels. Each level addresses a broad array of self-care behaviors and offers deep insight into the characteristics that drive health activation. A PAM score can also predict healthcare outcomes including medication adherence, ER utilization and hospitalization.

- 6.27. **"Participant"** is a Beneficiary who agrees to take part in Health Home Services as demonstrated by the Health Action Plan.
- 6.28. **"Participation Rate"** means during a given period of time, the number of beneficiaries who elect to participate in Health Home Services divided by that total number of clients assigned to the Contractor by HCA.
- 6.29. **"Passive Enrollment"** means the ability to enroll an eligible Beneficiary into a Qualified Health Home without their direct consent. Passive enrollment must include an opt-out feature that allows beneficiaries to discontinue enrollment at any time within HCA disenrollment rules.
- 6.30. **"PRISM User Coordinator"** means the employee appointed by the Contractor to be the point of contact for HCA staff and DSHS's PRISM Administration Team.
- 6.31. **"Qualified Health Home"** is a lead entity qualified by the state to coordinate Health Home Services for eligible beneficiaries. The Qualified Health Home is responsible for administration and oversight functions of the coordination and integration of care across the continuum of services needed and used by Participants. The Qualified Health Home includes a network of community-based Care Coordination Organizations that coordinate and may provide primary care, acute care, mental health services, substance use disorder services, and long term services and supports to eligible beneficiaries, including providers from the local community that authorize Medicaid, state or federally funded services.
- 6.32. **"Rate Tiers"** means a three tier system of payment for Health Home services which make separate payments for:
- 6.32.1. Outreach, engagement and Health Action Plan,
 - 6.32.2. Intensive Health Home Care Coordination, and
 - 6.32.3. Low Level Health Home Care Coordination.

7. GENERAL TERMS AND CONDITIONS

- 7.1. **Entire Contract:** This Contract including referenced exhibits represents all the terms and conditions agreed upon by the parties. No other understandings or representations, oral or otherwise, regarding the subject matter of this Contract shall be deemed to exist or to bind any of the parties hereto.
- 7.2. **Incorporation by Reference:** The following documents are incorporated into this Contract by reference:
- 7.2.1. State of Washington, Health Care Authority, Request for Applications # 12-005;
 - 7.2.2. Contractor's Application in Response to Request for Applications # 12-005;
 - 7.2.3. State of Washington, Health Care Authority, Encounter Data Reporting Guide.
 - 7.2.4. State of Washington, Health Care Authority, OneHealthPort Canonical Guide.

- 7.3. **Assurances:** HCA and the Contractor agree that all activity pursuant to this Contract will be in accordance with all the applicable current federal, state and local laws, rules, and regulations.
- 7.4. **Records Retention:** The Contractors shall maintain adequate records of services, charges, dates, and other commonly accepted information elements for services rendered pursuant to this Contract.
- 7.4.1. All Financial records shall follow generally accepted accounting principles.
- 7.4.2. Medical records and supporting management systems shall include pertinent information related to the medical management of each Beneficiary.
- 7.4.3. Other records shall be maintained as necessary to clearly reflect all actions taken by the contractor related to services provided under this Contract.
- 7.4.4. Records shall be maintained for a period of no less than six (6) years from the close of the Contract, or such other period as required by law.
- 7.4.5. If records are under review or audit they must be retained for a minimum of six (6) years following resolution of such action.
- 7.5. **Records Access:** The contractor acknowledges and agrees that HCA and DSHS shall, upon reasonable notice, have access to records and facilities under this Contract.
- 7.5.1. The Contractor shall provide access to all Health Home related records, and supportive materials maintained by the contractor or any subcontracted entity.
- 7.5.2. The Contractor shall provide access to Health Home related portions of facilities, whether facilities of the Contractor or subcontractors.
- 7.6. **Audits and Investigations:** The Contractor acknowledges and agrees that HCA, DSHS, and their authorized representatives shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of this Contract and any other applicable rules.
- 7.6.1. The Contractor and all of its subcontractors shall cooperate with HCA and DSHS contract compliance audits, on-site reviews, and other evaluation activities required by this contract.
- 7.7. **Governing Law and Venue:** This Contract shall be construed and interpreted in accordance with the laws of the state of Washington and the venue of any action brought hereunder shall be in Superior Court for Thurston County.
- 7.8. **Conformance:** If any provision of this Contract violates any statute or rule of law of the State of Washington, it is considered modified to conform to that statute or rule of law.

7.9. **Order of Precedence:** Each of the Exhibits listed below is by this reference hereby incorporated into this Contract. In the event of an inconsistency in this Contract, the inconsistency shall be resolved by giving precedence in the following order:

7.9.1. Applicable Federal and State of Washington statutes and regulations

7.9.2. Terms and Conditions as contained in this Contract

7.9.3. Any other provision, term or material incorporated herein by reference or otherwise.

7.10. **Survivability:** The terms and conditions contained in this Contract which, by their sense and context, are intended to survive the expiration or termination of this Contract shall survive. Surviving terms include, but are not limited to: Billing Limitations; Confidentiality, Data Sharing, Disputes, Maintenance of Records, Notice of Overpayment, Ownership of Material, Termination for Default, Termination Procedure, and Treatment of Property.

7.11. **Severability:** If any term or condition of this Contract is held invalid by any court, the remainder of this Contract remains valid and in full force and effect.

7.12. **Force Majeure:** If the Contractor is prevented from performing any or all of its obligations hereunder, because of a major epidemic, act of God, war, terrorist act, civil disturbance, court order, or any other cause beyond its control; such nonperformance shall not be grounds for termination for default. Immediately upon the occurrence of any such event, the Contractor shall commence to use its best efforts to directly or indirectly provide, alternate and, to the extent practicable, comparable performance of its obligations. Nothing in this Section shall be construed to prevent HCA from terminating this Contract for reasons other than for default during the period of event set forth above, or for default, if such default occurred prior to such event.

7.13. **Insurance:** The Contractor shall at all times comply with the following insurance requirements.

7.13.1. The Contractor shall maintain Commercial General Liability Insurance, or Business Liability Insurance, including coverage for bodily injury, property damage, and contractual liability, with the following minimum limits: Each Occurrence - \$1,000,000; General Aggregate - \$2,000,000. The policy shall include liability arising out of premises, operations, independent contractors, products-completed operations, personal injury, advertising injury, and liability assumed under an insured contract. The State of Washington, Health Care Authority (HCA), and its elected and appointed officials, agents, and employees of the state, shall be named as additional insureds.

7.13.1.1. In lieu of general liability insurance mentioned above, if the Contractor is a sole proprietor with less than three contracts, the Contractor may choose one of the following three general liability policies-but only if attached to a professional liability policy, and if selected, the policy shall be maintained for the life of this Contract:

- 7.13.1.1.1. Supplemental Liability Insurance, including coverage for bodily injury and property damage that will cover the Contractor wherever the service is performed with the following minimum limits: Each Occurrence - \$1,000,000; General Aggregate - \$2,000,000. The State of Washington, Health Care Authority (HCA), its elected and appointed officials, agents, and employees shall be named as additional insureds.
- 7.13.1.1.2. Workplace Liability Insurance, including coverage for bodily injury and property damage that provides coverage wherever the service is performed with the following minimum limits: Each Occurrence - \$1,000,000; General Aggregate - \$2,000,000. The State of Washington, Health Care Authority (HCA), and its elected and appointed officials, agents, and employees of the state, shall be named as additional insureds.
- 7.13.1.1.3. Premises Liability Insurance and provide services only at their recognized place of business, including coverage for bodily injury, property damage with the following minimum limits: Each Occurrence - \$1,000,000; General Aggregate - \$2,000,000. The State of Washington, Health Care Authority (HCA), and its elected and appointed officials, agents, and employees of the state, shall be named as Additional Insured.
- 7.13.2. The Contractor shall maintain a Business Automobile Liability Insurance Policy on all vehicles used to transport Beneficiaries, including vehicles hired by the Contractor or owned by the Contractor's employees, volunteers or others, with the following minimum limits: \$1,000,000 per accident combined single limit. The Contractor's carrier shall provide HCA with a waiver of subrogation or name HCA as an Additional Insured.
- 7.13.3. The Contractor shall maintain Professional Liability Insurance or Errors & Omissions insurance, including coverage for losses caused by errors and omissions, with the following minimum limits: Each Occurrence - \$1,000,000; Aggregate - \$2,000,000.
- 7.13.4. The Contractor shall comply with all applicable Worker's Compensation, occupational disease, and occupational health and safety laws and regulations. The State of Washington and HCA shall not be held responsible for claims filed for Worker's Compensation under Title 51 RCW by the Contractor or its employees under such laws and regulations.
- 7.13.5. Insurance required of the Contractor under this Contract shall include coverage for the acts and omissions of the Contractor's employees and volunteers. In addition, the Contractor shall ensure that all employees and volunteers who use vehicles to transport clients or deliver services have personal automobile insurance and current driver's licenses.
- 7.13.6. The Contractor shall ensure that all subcontractors have and maintain insurance with the same types and limits of coverage as required of the Contractor under this Contract.

- 7.13.7. All insurance policies shall include coverage for cross liability and contain a "Separation of Insured's" provision.
- 7.13.8. The Contractor shall obtain insurance from insurance companies identified as an admitted insurer/carrier in the State of Washington, with a Best's Reports' rating of B++, Class VII, or better. Surplus Lines insurance companies will have a rating of A-, Class VII, or better.
- 7.13.9. The Contractor, upon request by HCA Acquisition and Risk Management Services staff, shall submit a copy of the Certificate of Insurance, policy, and additional insured endorsement for each coverage required of the Contractor under this Contract.
- 7.13.9.1. The Certificate of Insurance shall identify the Washington State Health Care Authority (HCA) as the Certificate Holder.
- 7.13.9.2. A duly authorized representative of each insurer, showing compliance with the insurance requirements specified in this Contract, shall execute each Certificate of Insurance.
- 7.13.9.3. The Contractor is not required to submit to the HCA copies of Certificates of Insurance for personal automobile insurance required of the Contractor's employees and volunteers under this Contract.
- 7.13.9.4. The Contractor shall maintain copies of Certificates of Insurance for each subcontractor as evidence that each subcontractor maintains insurance as required by this Contract.
- 7.13.10. The insurer shall give HCA 45 days advance written notice of cancellation or non-renewal. If cancellation is due to non-payment of premium, the insurer shall give HCA 10 days advance written notice of cancellation.
- 7.13.11. By requiring insurance, the State of Washington and HCA do not represent that the coverage and limits specified will be adequate to protect the Contractor. Such coverage and limits shall not be construed to relieve the Contractor from liability in excess of the required coverage and limits and shall not limit the Contractor's liability under the indemnities and reimbursements granted to the State and HCA in this Contract. All insurance provided in compliance with this Contract shall be primary as to any other insurance or self-insurance programs afforded to or maintained by the State.
- 7.14. **Registration with State of Washington:** The Contractor shall be responsible for registering with Washington State agencies, including but not limited to, the Washington State Department of Revenue, the Washington Secretary of State's Corporations Division and the Washington State Office of Financial Management, Division of Information Services' Statewide Vendors program.
- 7.15. **Waiver:** Waiver of any breach or default on any occasion shall not be deemed to be a waiver of any subsequent breach or default. Any waiver shall not be construed to be a modification of the terms and conditions of this Contract. Only the HCA

Contracts Administrator or designee has the authority to waive any term or condition of this Contract on behalf of HCA.

- 7.16. **Disputes:** The parties shall use their best, good faith efforts to cooperatively resolve disputes and problems that arise in connection with this Contract. Both parties will continue without delay to carry out their respective responsibilities under this Contract while attempting to resolve the dispute under this Section. When a genuine dispute arises between HCA and the Contractor regarding the terms of this Contract or the responsibilities imposed herein which cannot be resolved at the project management level, either party may submit a request for a dispute resolution to the Contract Administrator which shall oversee the following Dispute Resolution Process: HCA shall appoint a representative to a dispute panel; the Contractor shall appoint a representative to the dispute panel; HCA's and Contractor's representatives shall mutually agree on a third person to chair the dispute panel. The dispute panel shall thereafter decide the dispute with the majority prevailing.

7.16.1. A party's request for a dispute resolution must:

7.16.1.1. Be in writing;

7.16.1.2. State the disputed issues;

7.16.1.3. State the relative positions of the parties;

7.16.1.4. State the contractor's name, address, and his/her department contract number;

7.16.1.5. Be mailed to HCA Contracts Office, PO Box 42702, Olympia, WA 98504-2702 within thirty (30) calendar days after the party could reasonably be expected to have knowledge of the issue which he/she now disputes.

7.16.2. This dispute resolution process constitutes the sole administrative remedy available under this Contract. The parties agree that this resolution process shall precede any action in a judicial and quasi-judicial tribunal.

7.17. **Notices:** Whenever one party is required to give notice to the other party under this Contract, it shall be deemed given if mailed by the United States Postal Service (USPS), as registered or certified mail, with a return receipt requested, postage prepaid and addressed as follows:

7.17.1. In the case of notice to the Contractor, notice shall be sent to the point of contact identified on page one (1) of this Contract;

7.17.2. In the case of notice to HCA, notice shall be sent to:

Acquisition and Risk Management Services
Legal and Administrative Services
Washington State Health Care Authority
P. O. Box 42702

- 7.17.3. Notice shall become effective on the date delivered as evidenced by the return receipt or the date returned to sender for non-delivery other than for insufficient postage. Either party may at any time change its address for notification purposes by mailing a notice in accordance with this Section, stating the change and setting forth the new address, which shall be effective on the tenth (10th) day following the effective date of such notice unless a later day is specified in the notice.
- 7.18. **Notice of Overpayment:** If the Contractor receives a vendor overpayment notice or a letter communicating the existence of an overpayment from the Washington State Department of Social and Health Services, Office of Financial Recovery (OFR), the Contractor may protest the overpayment determination by requesting an adjudicative proceeding.
 - 7.18.1. The Contractor's request for an adjudicative proceeding must:
 - 7.18.1.1. Be received by the OFR at Post Office Box 9501, Olympia, Washington 98507-9501, within twenty-eight (28) calendar days of service of the notice;
 - 7.18.1.2. Be sent by certified mail (return receipt) or other manner that proves OFR received the request;
 - 7.18.1.3. Include a statement as to why the Contractor thinks the notice is incorrect; and
 - 7.18.1.4. Include a copy of the overpayment notice.
 - 7.18.2. Timely and complete requests will be scheduled for a formal hearing by the Washington State Office of Administrative Hearings. The Contractor may be offered a pre-hearing or alternative dispute resolution conference in an attempt to resolve the overpayment dispute prior to the hearing.
 - 7.18.3. Failure to provide OFR with a written request for a hearing within twenty-eight (28) days of service of a vendor overpayment notice or other overpayment letter will result in an overpayment debt against the Contractor. HCA may charge the Contractor interest and any costs associated with the collection of this overpayment. HCA may collect an overpayment debt through lien, foreclosure, seizure and sale of the Contractor's real or personal property; order to withhold and deliver; or any other collection action available to HCA to satisfy the overpayment debt.
- 7.19. **Savings:** In the event funding from State, federal or other sources is withdrawn, reduced, or limited in any way after the effective date of this Contract and prior to its completion or termination, HCA may terminate this Contract under the "Termination Due to Change in Funding" Section, without the ten (10) day notice requirement, subject to renegotiation at HCA's discretion under those new funding limitations and conditions

- 7.20. **Termination for Convenience:** Either party may terminate this Contract in whole or in part when it is in that party's best interest, by giving fifteen (15) business days written notice, beginning on the second (2nd) day after the mailing. If this Contract is so terminated, the HCA shall be liable only for payment in accordance with the terms of this Contract for services rendered prior to the effective date of termination.
- 7.21. **Termination for Default:** If for any cause, either party fails to fulfill its obligations under this Agreement in a timely and proper manner, or if either party violates any of the terms and conditions contained in this Agreement, then the aggrieved party will give the other party written notice of such failure or violation. The responsible party will be given thirty (30) working days to correct the violation or failure. If the failure or violation is not corrected, this Agreement may be terminated by written notice from the aggrieved party to the other party.
- 7.21.1. HCA reserves the right to suspend all or part of this Contract, withhold further payments, or prohibit the Contractor from incurring additional obligations of funds during investigation of an alleged compliance breach and pending corrective action by the Contractor.
- 7.21.2. In the event this Contract is terminated by either party for default, the responsible party shall be liable for damages as authorized by law.
- 7.22. **Termination Due to Change in Funding:** If the funds HCA relied upon to establish this Contract are withdrawn, reduced or limited, or if additional or modified conditions are placed on such funding, HCA may immediately terminate or unilaterally amend this Contract by providing written notice to the Contractor. The termination shall be effective on the date specified in the termination notice.
- 7.23. **Termination or Expiration Procedures:** The following terms and conditions apply upon Contract termination or expiration:
- 7.23.1. HCA, in addition to any other rights provided in this Contract, may require the Contractor to deliver to HCA any property specifically produced or acquired for the performance of such part of this Contract as has been terminated.
- 7.23.2. HCA shall pay to the Contractor the agreed upon price, if separately stated, for completed work and service accepted by HCA's program staff and the amount agreed upon by the Contractor and HCA for:
- 7.23.2.1. Completed work and services for which no separate price is stated;
- 7.23.2.2. Partially completed work and services;
- 7.23.2.3. Other property or services which are accepted by HCA's program staff; and
- 7.23.2.4. The protection and preservation of property, unless the termination is for default, in which case the Agent or designee shall determine the extent of the liability. Failure to agree with such determination shall be a dispute within the meaning of the "Disputes" Section of this Contract. HCA may withhold from any amounts due the Contractor such sum as

the Agent or designee determines to be necessary to protect HCA against potential loss or liability.

7.23.3. The rights and remedies of HCA provided in this Section shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

7.23.3.1. After receipt of notice of termination, and except as otherwise directed by the Agent or designee, the Contractor shall:

7.23.3.2. Stop work under this Contract on the date, and to the extent specified in the notice;

7.23.3.3. Place no further orders or subcontracts for materials, services, or facilities except as may be necessary for completion of such portion of the work under this Contract that is not terminated;

7.23.3.4. Assign to HCA, in the manner, at the times, and to the extent directed by the Agent or designee, all the rights, title, and interest of the Contractor under the orders and subcontracts so terminated; in which case HCA has the right, at its discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts;

7.23.3.5. Settle all outstanding liabilities and all claims arising out of such termination of orders and subcontracts, with the approval or ratification of the Agent or designee to the extent the Agent or designee may require, which approval or ratification shall be final for all the purposes of this Section;

7.23.3.6. Transfer title to HCA and deliver in the manner, at the times, and to the extent directed by the Agent or designee any property which, if this Contract had been completed, would have been required to be furnished to HCA;

7.23.3.7. Complete performance of such part of the work as shall not have been terminated by the Agent or designee; and

7.23.3.8. Take such action as may be necessary, or as the Agent or designee may direct, for the protection and preservation of the property related to this Contract which is in the possession of the Contractor and in which HCA has or may acquire an interest.

8. PROGRAM INTEGRITY

8.1. **Disclosure of Information on Ownership and Control:** The Contractor must provide the following disclosures:

8.1.1. The name and address of any person (individual or corporation) with an ownership or control interest in the Contractor. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

- 8.1.2. Date of birth and Social Security Number (in the case of an individual).
- 8.1.3. Other tax identification number (in the case of a corporation) with an ownership or control interest in the Contractor or in any subcontractor in which the Contractor has a five (5) percent or more interest;
- 8.1.4. Whether the person (individual or corporation) with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the Contractor has a five (5) percent or more interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling.
- 8.1.5. The name of any other Contractor in which an owner of the Contractor has an ownership or control interest;
- 8.1.6. The name, address, date of birth, and Social Security Number of any managing employee of the Contractor.
- 8.1.7. Disclosures from the Contractor shall be submitted to HCA through the Health Homes email address (healthhomes@hca.wa.gov) at any of the following times:
 - 8.1.7.1. Upon the Contractor submitting the proposal in accordance with HCA's procurement process;
 - 8.1.7.2. Upon the Contractor signing the Contract with HCA;
 - 8.1.7.3. Upon renewal or extension of the Contract; and
 - 8.1.7.4. Within 35 days after any change in ownership of the Contractor..
- 8.2. **Professional Credentialing and Licensure:** If the Contractor, its employees, and/or subcontractors who shall be in contact with HCA Clients while performing work under this Contract must be accredited, certified, licensed or registered according to Washington state laws and regulations; the Contractor shall ensure that all such individuals do not have, and shall remain without during the term of this Contract, restrictions or sanctions placed on such accreditation, certification, license and/or registration. The Contractor shall notify the HCA Acquisition and Risk Management Services staff within three (3) business days of receipt of information relating to disciplinary action against the accreditation, certification, license and/or registration of the Contractor, an employee, subcontractor or subcontractor employee.
- 8.3. **Excluded Individual and Entities:** The Contractor is prohibited from paying with funds received under this Contract for goods and services furnished, ordered or prescribed by excluded individuals and entities (Social Security Act (SSA) section 1903(i)(2) of the Act; 42 CFR §455.104, 42 CFR §455.106, and 42 CFR §1001.1901(b)).

8.3.1. The Contractor shall monitor for excluded individuals and entities by:

8.3.1.1. Screening Contractor and subcontractor's employees and individuals and entities with an ownership or control interest for excluded individuals and entities prior to entering into a contractual or other relationship where the individual or entity would benefit directly or indirectly from funds received under this Contract.

8.3.1.2. Screening monthly newly added Contractor and subcontractor's employees and individuals and entities with an ownership or control interest for excluded individuals and entities that would benefit directly or indirectly from funds received under this Contract.

8.3.1.3. Screening monthly Contractor and subcontractor's employees and individuals and entities with an ownership or control interest that would benefit from funds received under this Contract for newly added excluded individuals and entities.

8.4. **Background Checks:** The Contractor shall ensure that a criminal history background check is performed on all employees, volunteers and subcontractor staff who may have unsupervised access to children and/or Vulnerable Adults, as defined by RCW 43.43.830(14), served under this Contract.

8.4.1. Such criminal history background check shall be consistent with RCW 43.43.832, 43.43.834, RCW 43.20A.710 and Chapter 388-06 WAC.

8.4.2. The Contractor shall not give employees, volunteers, and subcontractor staff access to children and/or Vulnerable Adults until a criminal history background check is performed.

8.5. **Fraud and Abuse Requirements:** The Contractor shall report in writing all verified cases of fraud and abuse, including fraud and abuse by the Contractor's employees, subcontractors and/or subcontractor employees, within five (5) business days, to the HCA Acquisition and Risk Management Services staff. The report shall include the following information:

8.5.1. Subject(s) of complaint by name and either provider/subcontractor type or employee position;

8.5.2. Source of complaint by name and provider/subcontractor type or employee position;

8.5.3. Nature of complaint;

8.5.4. Estimate of the amount of funds involved; and

8.5.5. Legal and administrative disposition of case;

9. DATA SHARING

- 9.1. **Justification for Data Sharing:** Data is needed to facilitate the Contractor's performance of work as described in Section 11, Statement of Work, of this Contract.
- 9.2. **Functions of Responsible Parties:** HCA, DSHS, and the Contractor shall comply with the data sharing functions and responsibilities described herein.
 - 9.2.1. **HCA Functions:** HCA shall provide all technical assistance necessary for and incidental to the support of the Contractor's performance under this Contract; and monitor the use and disclosure of Data and suspend or terminate access privileges for unauthorized activity.
 - 9.2.2. **DSHS Functions:** DSHS shall provide all technical assistance necessary for PRISM access; and monitor continuously the use of PRISM and suspend or terminate privileges for unusual or potentially unauthorized access, uses, or disclosures.
 - 9.2.3. **Contractor Functions:** The Contractor shall use the Data made available to it as a result of this Contract solely for the purposes of this Contract.
 - 9.2.3.1. The Contractor Coordinator shall identify all Designated Staff who have a business need to access PRISM.
 - 9.2.3.2. The Contractor shall ensure that Designated Staff complete and submit to the DSHS PRISM Administration Team all necessary forms required by CMS and DSHS for data authorization and PRISM access, including:
 - 9.2.3.2.1. The PRISM registration form,
 - 9.2.3.2.2. The Nondisclosure of HCA Confidential Information form (Exhibit A),
 - 9.2.3.2.3. The DSHS provided spreadsheet.
 - 9.2.3.3. The Contractor shall ensure Designated Staff receive an annual written reminder of the required Nondisclosure of HCA Confidential Information requirements.
 - 9.2.3.4. The Contractor shall promptly notify the HCA Acquisition and Risk Management Services and the DSHS PRISM Administration Team when established Designated Staff user accounts should be removed due to employment termination, job reassignment, or other changes in circumstances.
 - 9.2.3.5. The Contractor shall maintain and provide to HCA or DSHS upon request a list of all subcontracted CCOs and Health Home Provider Business Associates who have accessed Data as a result of this Contract.

9.2.3.6. The Contractor shall comply with the privacy, data security, permitted data usage requirements and data use restrictions contained in:

9.2.3.6.1. Data Security Requirements (Subsection 9.7.);

9.2.3.6.2. Data Handling Requirements (Subsection 9.8.);

9.2.3.6.3. Information Exchange Agreement between Centers for Medicare & Medicaid Services Washington State Health Care Authority for Disclosure of Medicare Part D Data (CMS Agreement No. 2011-13) as pertains to Medicare Data provided by the Contractor,

9.2.3.6.4. Medicare Part D Data Use Agreement No. 21628, Agreement for Use of Centers for Medicare & Medicaid Services Data Containing Individual Identifiers and addenda,

9.2.3.6.5. Medicare Part D Attachment A, and

9.2.3.6.6. HCA staff shall provide the Contractor with copies of the documents referenced under this section of the contract upon execution.

9.2.3.7. The Contractor shall establish a Business Associate Agreement with HCA.

9.3. **Data Classification:** The Contractor's data classifications must translate to or include the following classification categories:

9.3.1. **Category 1 – Public Information:** Public information is information that can be or currently is released to the public. It does not need protection from unauthorized disclosure, but does need integrity and availability protection controls.

9.3.2. **Category 2 – Sensitive Information:** Sensitive information may not be specifically protected from disclosure by law and is for official use only. Sensitive information is generally not released to the public unless specifically requested.

9.3.3. **Category 3 – Confidential Information:** Confidential information is information that is specifically protected from disclosure by law. It may include but is not limited to:

9.3.3.1. Personal information about individuals, regardless of how that information is obtained;

9.3.3.2. Information concerning employee personnel records;

9.3.3.3. Information regarding IT infrastructure and security of computer and telecommunications systems;

9.3.3.4. Business Associates Agreement (BAA) required.

9.3.4. Category 4 – Confidential Information Requiring Special Handling:

Confidential information requiring special handling is information that is specifically protected from disclosure by law and for which:

9.3.4.1. Especially strict handling requirements are dictated, such as by statutes, regulations, or agreements.

9.3.4.2. Serious consequences could arise from unauthorized disclosure, such as threats to health and safety, or legal sanctions.

9.3.4.3. Business Associates Agreement (BAA) required.

9.4. Permitted Data Use: The Contractor shall limit its use and disclosure of HCA Data to purposes identified in this Contract.

9.4.1. The Contractor shall obtain HCA's authorization prior to making any reports containing results based on HCA Data publicly available.

9.5. Restrictions on Data Use: The Contractor shall:

9.5.1. Limit the authorization and authentication of Designated Staff to only those employees whose duties include one or more of the following:

9.5.1.1. Providing, coordinating, or managing care and/or services for Beneficiaries,

9.5.1.2. Determining eligibility, monitoring caseloads, and/or identifying high-risk Beneficiaries,

9.5.1.3. Quality Improvement activities, and

9.5.1.4. Assessing, referring, and case managing Beneficiaries;

9.5.2. Restrict access by Designated Staff to no more than the minimum amount of information necessary to perform job duties;

9.5.3. Strictly sanction the access, use, or disclosure of Data for purposes not related to job duties. Such sanction includes dismissal if the severity of the misuse or disclosure is determined by HCA or DSHS PRISM Administration; and

9.5.4. Limit access by Designated Staff to looking-up information on Individual Beneficiaries unless the Designated Staff person's job duties require authorized access to a list of Beneficiaries.

9.6. Data Access Requirements: HCA and DSHS PRISM Administration shall limit access by the Contractor's Designated Staff:

9.6.1. Who have been identified to HCA's Enterprise Technology Services (ETS) staff and DSHS's RDA staff as authorized and authenticated Designated Staff; and

- 9.6.2. Whose duties specifically require access to such Data obtained either directly from HCA or from PRISM in the performance of their assigned duties; and
- 9.6.3. Who as an employee of the Contractor shall prior to HCA's Enterprise Technology Services staff providing Unique User ID and Hardened Password to access the Data shall have been notified by the Contractor of the Nondisclosure requirements specified in Exhibit A, Nondisclosure of HCA Confidential Information.
- 9.6.4. The Contractor, for both its own Designated Staff, shall ensure that all receive an annual written reminder of the required HCA Data Nondisclosure requirements. The Contractor shall require that its employees with access to HCA Data complete and re-submit a new Nondisclosure form upon renewal of this Contract.
- 9.7. **Data Security Requirements:** The Contractor shall not use, publish, transfer, sell or otherwise disclose any Confidential Information gained by reason of this Contract for any purpose that is not directly connected with Contractor's performance of the services contemplated hereunder, except in the case of Personal Information, with the prior written consent of the person or personal representative of the person who is the subject of the personal information; or as permitted by law.
 - 9.7.1. The Contractor shall protect and maintain all Confidential Information gained by reason of this Contract against unauthorized use, access, disclosure, modification or loss. This duty requires the Contractor to employ reasonable security measures, which include restricting access to the Confidential Information by:
 - 9.7.1.1. Allowing access only to staff that have an authorized business requirement to view the Confidential Information;
 - 9.7.1.2. Physically securing any computers, documents, or other media containing the Confidential Information; and
 - 9.7.1.3. Ensuring the security of Confidential Information transmitted via fax (facsimile) by:
 - 9.7.1.3.1. Verifying the recipient phone number to prevent accidental transmittal of Confidential Information to unauthorized persons;
 - 9.7.1.3.2. Communicating with the intended recipient before transmission to ensure that the fax will be received only by an authorized person; and
 - 9.7.1.3.3. Verifying after transmittal that the fax was received by the intended recipient;
 - 9.7.2. When transporting six (6) or more records containing Confidential Information, outside a Secured Area, do one or more of the following as appropriate:
 - 9.7.2.1. Use a Trusted System.

9.7.2.2. Encrypt the Confidential Information, including:

9.7.2.2.1. Encrypting email and/or email attachments which contain the Confidential Information; and

9.7.2.2.2. Encrypting Confidential Information when it is stored on portable devices or media, including but not limited to laptop computers and flash memory devices.

9.7.2.3. Send paper documents containing Confidential Information via a Trusted System.

9.7.3. The Contractor shall not release, divulge, publish, transfer, sell, disclose, or otherwise make the Confidential Information or Sensitive Data known to any other entity or person without the express prior written consent of HCA's Public Disclosure Office, or as required by law.

9.7.4. If responding to public record disclosure requests under Chapter 42.56 RCW, the Contractor agrees to notify and discuss with HCA's Public Disclosure Officer requests for all information that are part of this Contract, prior to disclosing the information. HCA upon request shall provide the Contractor with the name and contact information for HCA Public Disclosure Officer. The Contractor further agrees to provide HCA with a minimum of two calendar weeks to initiate legal action to secure a protective order under RCW 42.56.540.

9.8. **Data Handling Requirements:** The Contractor shall store Data on one or more of the following media and protect the Data as described:

9.8.1. **Hard disk drives:** Data stored on local workstation hard disks. Access to the Data will be restricted to Authorized User(s) by requiring logon to the local workstation using a Unique User ID and Hardened Password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards.

9.8.2. **Network server disks:** Data stored on hard disks mounted on network servers and made available through shared folders. Access to the Data will be restricted to Authorized Users through the use of access control lists which will grant access only after the Authorized User has authenticated to the network using a Unique User ID and Hardened Password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Data on disks mounted to such servers must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.

9.8.2.1. For HCA Confidential Information stored on these disks, deleting unneeded Data is sufficient as long as the disks remain in a Secured Area and otherwise meet the requirements listed in the above paragraph. Destruction of the Data is outlined in Subsection 9.10. Data destruction may be deferred until the disks are retired, replaced, or otherwise taken out of the Secured Area.

- 9.8.3. **Removable Media, including Optical discs (CDs or DVDs) in local workstation optical disc drives and which will not be transported out of a secure area:** Sensitive or Confidential Data provided by HCA on removable media, such as optical discs or USB drives, which will be used in local workstation optical disc drives or USB connections shall be encrypted with 128-bit AES encryption or better. When not in use for the contracted purpose, such discs must be locked in a drawer, cabinet or other container to which only authorized users have the key, combination or mechanism required to access the contents of the container. Workstations which access HCA Data on optical discs must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.
- 9.8.4. **Optical discs (CDs or DVDs) in drives or jukeboxes attached to servers and which will not be transported out of a secure area:** Data provided by HCA on optical discs which will be attached to network servers shall be encrypted with 128-bit AES encryption or better. Access to Data on these discs will be restricted to authorized users through the use of access control lists which will grant access only after the authorized user has been authenticated to the network using a unique user ID and complex password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Data on discs attached to such servers must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.
- 9.8.5. **Paper documents:** Any paper records must be protected by storing the records in a secure area which is only accessible to authorized personnel. When not in use, such records must be stored in a locked container, such as a file cabinet, locking drawer, or safe, to which only authorized persons have access.
- 9.8.6. **Access via remote terminal/workstation over the State Governmental Network (SGN):** Data accessed and used interactively over the SGN. Access to the Data will be controlled by HCA staff who will issue authentication credentials (e.g. a unique user ID and complex password) to authorized contractor staff. Contractor shall have established and documented termination procedures for existing staff with access to HCA Data. These procedures shall be provided to HCA staff upon request. The Contractor will notify HCA staff immediately whenever an authorized person in possession of such credentials is terminated or otherwise leaves the employ of the contractor, and whenever a user's duties change such that the user no longer requires access to perform work for this Contract.
- 9.8.7. **Access via remote terminal/workstation over the Internet through Secure Access Washington:** Data accessed and used interactively over the Internet. Access to the Data will be controlled by HCA staff who will issue remote access authentication credentials (e.g. a unique user ID and complex password) to authorized contractor staff. Contractor will notify HCA staff immediately whenever an authorized person in possession of such credentials is terminated or otherwise leaves the employ of the contractor and whenever a user's duties

change such that the user no longer requires access to perform work for this Contract.

9.8.8. Data storage on portable devices or media: HCA Data shall not be stored by the Contractor on portable devices or media unless specifically authorized within the terms and conditions of this contract.

9.8.8.1. Portable devices include any small computing device that can be transported. They include, but are not limited to; handhelds/PDAs/phones, Ultra mobile PCs, flash memory devices (e.g. USB flash drives, personal media players), and laptop/notebook/tablet computers.

9.8.8.2. Portable media includes any Data storage that can be detached or removed from a computer and transported. They include, but are not limited to; optical media (e.g. CDs, DVDs), magnetic media (e.g. floppy disks, tape,), USB drives, or flash media (e.g. CompactFlash, SD, MMC).

9.8.8.3. When being transported outside of a secure area, portable devices and media with confidential HCA Data must be under the physical control of contractor staff with authorization to access the Data.

9.8.8.4. Data stored on portable devices or media shall be given the following protections:

9.8.8.4.1. Encrypt the Data with a key length of at least 128 bits using an industry standard algorithm (e.g., AES)

9.8.8.4.2. Control access to devices with a unique user ID and password or stronger authentication method such as a physical token.

9.8.8.4.3. Manually lock devices whenever they are left unattended and set devices to lock automatically after a period of inactivity, if this feature is available. Maximum period of inactivity is 20 minutes.

9.8.8.4.4. Physically protect the portable device(s) and/or media by:

9.8.8.4.4.1. Keeping them in locked storage when not in use

9.8.8.4.4.2. Using check-in/check-out procedures when they are shared, and

9.8.8.4.4.3. Maintaining an inventory

9.9. Data Transmission: When transmitting HCA Confidential Information electronically, including via email, the Data shall be protected by:

9.9.1. Transmitting it within the (State Governmental Network) SGN or Contractor's internal network, or;

9.9.2. Encrypting any Data that will be transmitted outside the SGN or Contractor's internal network with 128-bit Advanced Encryption Standard (AES) encryption or better, including transmission over the public Internet;

9.10. **Destruction of Data:** When the contracted work has been completed or when no longer needed, Data shall be returned to HCA or destroyed.

9.10.1. If return, delivery, or destruction is not feasible, the protections of this Agreement will continue to apply to such Data and further uses and disclosures of the Data shall be limited to those purposes that make the return or destruction of the Data infeasible.

9.10.2. Media on which Data may be stored and associated acceptable methods of destruction are as follows:

DATA STORED ON:	WILL BE DESTROYED BY:
Server or workstation hard disks, or Removable media (e.g. floppies, USB flash drives, portable hard disks, Zip or similar disks)	Using a "wipe" utility which will overwrite the Data at least three (3) times using either random or single character Data, or Degaussing sufficiently to ensure that the Data cannot be reconstructed, or Physically destroying the disk
Paper documents with sensitive or confidential Data	Recycling through a contracted firm provided the contract with the recycler assures that the confidentiality of Data will be protected.
Paper documents containing confidential information requiring special handling (e.g. protected health information)	On-site cross-cut shredding by a method that renders the Data unreadable, pulping, or incineration
Optical discs (e.g. CDs or DVDs)	Incineration, shredding, or cutting/breaking into small pieces.
Magnetic tape	Degaussing, incinerating or crosscut shredding

9.11. **Notification of Compromise or Potential Compromise:** For purposes of this provision, "breach" has the meaning defined in 45 CFR § 164.402.

9.11.1. The Contractor shall have an established and documented policy to deal with the compromise or potential compromise of Data that complies with the HITECH Act of ARRA 2009. Contractor shall be responsible for any cost associated with a compromise or potential compromise.

9.11.2. Contractor will report to HCA any use or disclosure of the Protected Health Information not provided for by this Contract. Contractor will make these reports to the HCA contract manager within ten (10) days after the use or disclosure, or within ten (10) days after Contractor discovers a use or

disclosure that is likely to involve HCA members, whichever is later. If Contractor cannot provide conclusive information relating to the use or disclosure until a full investigation has occurred, then it will provide what information it can within ten (10) days, and full details no later than fifteen (15) days after discovery of the use or disclosure.

9.12. **Notification of Breach:** For purposes of this provision, "breach" has the meaning defined in 45 CFR § 164.402.

9.12.1. If Contractor or any subcontractor of it allegedly makes or causes, or fails to prevent, a use or disclosure constituting a Breach, and notification of that use or disclosure must (in the judgment of HCA) be made under 45 CFR part 164, subpart D (§§ 164.402 et seq.) or under RCW 19.255.010 or other applicable law, then:

9.12.1.1. HCA may choose to make the notifications or direct Contractor to make them, and

9.12.1.2. Contractor shall pay the costs of the notification and of other actions HCA considers appropriate to protect Beneficiaries (such as paying for regular credit watches), and

9.12.1.3. Contractor shall compensate Beneficiaries for harms caused to them by the Breach or possible Breach described above.

9.12.2. The Contractor will ensure that any entity, to whom it provides any Data, agrees to the same restrictions and conditions that apply to the Contractor with respect to such information.

10. PAYMENT

10.1. Payments for services rendered under this contract shall be made within available resources from:

10.1.1. Federal funds received under the Medical Assistance Program, CFDA # 93.778 from the United States Department of Health and Human Services; and

10.1.2. State of Washington General Funds-State appropriations.

10.2. The Contractor shall receive payment for one encounter per Participant per month upon submission of a valid service encounter to ProviderOne.

10.3. HCA shall consider payments made pursuant to this Contract to have been made timely if made by HCA within thirty (30) days of HCA's acceptance of a properly submitted service encounter. HCA may, at its sole discretion, withhold payment claimed by the Contractor for services rendered if Contractor fails to satisfactorily comply with any term or condition of this Contract.

10.4. Payments to the Contractor are incentive-based and shall be made according to the following rate tiers:

- 10.4.1. **Outreach, Engagement, and Health Action Plan Development:** The first tier in a three-tiered system and may include a variety of outreach methods, such as mail, phone, or home/doctor visits.
- 10.4.1.1. Outreach continues until the eligible Beneficiary either agrees to participate or declines participation in the Health Home program.
 - 10.4.1.2. Engagement occurs after the Beneficiary agrees to participate and a face-to-face visit is scheduled between the Participant and the Health Home Care Coordinator in a location of the Participant's choosing, such as their home or provider's office.
 - 10.4.1.3. Health Action Plan Development is a face-to-face visit to complete the Health Action Plan, which requires the Patient Activation Measure (PAM) or the Caregiver Activation Measure (CAM), other required screenings, coaching to assist the Participant in identifying short and long term goals and associated action steps, and a signed Health Home Information Sharing Consent form.
 - 10.4.1.4. HCA shall pay \$252.93 for Outreach, Engagement and Health Action Plan Development once in a life-time per Beneficiary. The rate includes time for preparation, planning, travel, and pre-populating the Health Action Plan with relevant PRISM utilization data.
- 10.4.2. **Intensive Health Home Care Coordination:** The highest level of Health Home Care Coordination services using one (1) or more elements of the six defined Health Home Services.
- 10.4.2.1. Intensive Health Home Care Coordination includes active engagement and direct contact with the Participant such as:
 - 10.4.2.1.1. Clinical, functional, and resource use screens, including screens for depression, alcohol or substance use disorder, functional impairment, and pain appropriate to the age and risk profile of the individual;
 - 10.4.2.1.2. Continuity and coordination of care through in-person visits, and the ability to accompany beneficiaries to health care provider appointments, as needed;
 - 10.4.2.1.3. Participant assessments to determine readiness for self-management and to promote self-management skills to improve functional or health status, or prevent or slow declines in functioning;
 - 10.4.2.1.4. Fostering communication between the providers of care including the treating primary care provider, medical specialists, personal care providers and others; and entities authorizing behavioral health and long-term services and supports;
 - 10.4.2.1.5. Promoting optimal clinical outcomes, including a description of

how progress toward outcomes will be measured through the Health Action Plan;

10.4.2.1.6. Health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes; and

10.4.2.1.7. Use of peer supports, support groups and self-care programs to increase the Participant's knowledge about their health care conditions and improve adherence to prescribed treatment.

10.4.2.2. HCA shall pay \$172.61 per Participant per month for Intensive Health Home Care Coordination.

10.4.3. **Low-Level Health Home Care Coordination:** Low-level Health Home Care Coordination occurs when the Participant and Health Home Care Coordinator identify that the Participant has achieved a sustainable level of progress toward meeting self-directed goals, or upon the Participant's request.

10.4.3.1. The Participant's health care needs and progress toward meeting self-directed goals shall be monitored using one (1) or more of the six defined Health Home Services.

10.4.3.2. At least one (1) Health Home Service shall be delivered per month through home visits or telephone calls.

10.4.3.3. HCA shall pay \$67.50 per Participant per month for Low-level Health Home Care Coordination.

10.5. **Incentive Payments:** HCA shall pay the full rate for Intensive Health Home Care Coordination and Low-Level Health Home Care Coordination for the first year of the Health Home program to allow the Contactor to build their infrastructure and increase their capacity to provide Health Home Services. HCA shall then make incentive payments starting January 1, 2015 according to the following methodology:

10.5.1. HCA shall calculate the Contractor's initial Participation Rate for the period that begins on the effective date of this Contract and ends on September 30, 2014.

10.5.2. HCA shall calculate the Contractor's Participation Rate annually thereafter based on the period of October 1 through September 30.

10.5.3. HCA shall calculate the Contractor's Participation Rate using ProviderOne enrollment and encounter data.

10.5.3.1. The denominator of the equation used to calculate the Participation Rate shall be the number of Beneficiaries that have been continuously enrolled with the Contractor for at least three (3) months and reported to the Contractor as Health Home eligible by HCA.

- 10.5.3.2. The numerator of the equation shall be the number of Beneficiaries for which the Contractor has successfully submitted at least one Health Home encounter.
- 10.5.4. HCA shall provide the Contractor with detailed reports that support the calculations of the Participation Rate no later than 60 days after the close of each reporting period.
- 10.5.5. HCA shall adjust payments for Intensive and Low-level Health Home Care Coordination on January 1 of each year. Payments shall then be made as follows based on the Contractor's Participation Rate for the reporting period immediately preceding:
 - 10.5.5.1. Intensive Health Home Care Coordination:
 - 10.5.5.1.1. An participation rate of 28% or higher will guarantee full payment, with no withhold applied;
 - 10.5.5.1.2. A participation rate of between 27.99% and 20% will result in a payment rate of \$171.45;
 - 10.5.5.1.3. A participation rate of between 19.99% and 15% will result in a payment rate of \$170.28, and
 - 10.5.5.1.4. A participation rate of less than 15% will result in a payment rate of \$169.16.
 - 10.5.5.2. Low-Level Health Home Care Coordination:
 - 10.5.5.2.1. A participation rate of 28% or higher will guarantee full payment, with no withhold applied;
 - 10.5.5.2.2. A participation rate of between 27.99% and 20% will result in a payment rate of \$67.05;
 - 10.5.5.2.3. A participation rate of between 19.99% and 15% will result in a payment rate of \$66.59, and
 - 10.5.5.2.4. A participation rate of less than 15% will result in a payment rate of \$66.15.
- 10.6. **Payment to CCOs:** The Contractor shall reimburse subcontracted Care Coordination Organizations for completed Health Home Services in accordance with the rates published at http://www.hca.wa.gov/pages/health_homes.aspx under Resources.

11. GRIEVANCE AND APPEAL SYSTEM

- 11.1. **General Requirements:** The Contractor shall have a grievance and appeals system which complies with the requirements of this section.

- 11.1.1. For the purposes of this Contract, "action" means the denial or limited authorization by the Contractor of a requested health home service, including the type or level of health home service; the reduction, suspension, or termination by the Contractor of a previously authorized health home service; and the failure of the Contractor to provide authorized health home services or provide health home services in a timely manner.
- 11.1.2. For the purposes of this Contract, "grievance" means an expression of Participant dissatisfaction about any matter other than an action. Possible subjects for grievances include the quality of health home services provided and aspects of interpersonal relationships such as rudeness.
- 11.2. **Grievance Process:** The following requirements are specific to the grievance process:
 - 11.2.1. Only a Participant or an individual authorized in writing by the Participant to act as his or her representative may file a grievance.
 - 11.2.2. The Participant or the Participant's authorized representative may file a grievance with the Contractor or with the Care Coordination Organization to which the Participant is assigned.
 - 11.2.3. A Health Home Care Coordinator may not file a grievance on behalf of a Participant unless the Health Home Care Coordinator is acting on behalf of the Participant and with the Participant's written consent.
 - 11.2.4. The Contractor shall accept, document, record, and process grievances forwarded by HCA.
 - 11.2.5. The Contractor shall acknowledge to the Participant and authorized representative receipt of each grievance, either orally or in writing, within two (2) business days.
 - 11.2.6. The Contractor shall assist the Participant with all grievance processes.
 - 11.2.7. The Contractor shall cooperate with any representative authorized in writing by the Participant.
 - 11.2.8. The Contractor shall ensure that decision makers on grievances were not involved in previous levels of review or decision-making.
 - 11.2.9. The Contractor shall consider all information submitted by the Participant or the Participant's representative.
 - 11.2.10. The Contractor shall investigate and resolve all grievances whether received orally or in writing. The Contractor shall not require a Participant or his/her authorized representative to provide additional written follow-up for a grievance the Contractor received orally.
 - 11.2.11. The Contractor shall complete the disposition of a grievance and notice to the affected parties as expeditiously as the Participant's health condition

requires, but no later than forty-five (45) calendar days from receipt of the grievance.

11.2.12. The Contractor must notify Participants and their authorized representatives (if applicable) of the disposition of grievances within five (5) business days of determination. The notification may be orally or in writing.

11.2.13. Notices of dispositions shall include information about how to request an administrative hearing if the Participant does not agree with the decision.

11.2.14. The Contractor shall maintain records of all grievances.

11.2.14.1. All grievances shall be counted and recorded whether the grievance is remedied by the Contractor immediately or through its grievance and quality of care service procedures.

11.2.14.2. Records shall include grievances handled by subcontracted CCOs.

11.2.14.3. Records of grievances shall include all expressions of Participant dissatisfaction.

11.3. **Appeal Process.** The following requirements are specific to the appeal process:

11.3.1. The Contractor shall give the Participant written notice of any action of the Contractor that denies a request for health home services; fails to act on the Participant's claim for health home services with reasonable promptness; authorizes a health home service in an amount, duration, or scope that is less than requested; or reduces, suspends, or terminates a previously authorized health home service. The written notice shall:

11.3.1.1. State what action the Contractor intends to make;

11.3.1.2. Explain the reasons for the Contractor's intended action;

11.3.1.3. Explain the specific rule or rules that support the Contractor's action, or the change in Federal or State law that requires the action;

11.3.1.4. Explain the Participant's right to appeal the action according to chapter 182-526 WAC;

11.3.1.5. State that the Participant must request a hearing within 90 days from the date that the notice of action is mailed;

11.3.1.6. State that in cases of an action based on a change in law, the circumstances under which a hearing will be granted; and

11.3.1.7. An explanation of the circumstances under which a health home service is continued if a hearing is requested;

11.3.2. The Contractor must send the written notice at least 10 days before the date of action except as permitted under 42 CFR 431.213 and § .214 and consistent with WAC 182-557-0350.;

- 11.3.3. A Health Home Care Coordinator may not file an appeal on behalf of a Participant unless the Health Home Care Coordinator is acting on behalf of the Participant and with the Participant's written consent.
- 11.3.4. If HCA receives a request to appeal an action of the Contractor, HCA will provide Contractor notice of the request.
- 11.3.5. HCA will process the Participant's appeal in accordance with chapter 182-526 WAC.
- 11.3.6. Contractor will continue the health home services that are the subject of the appeal if the Participant meets the requirements in chapter 182-526 WAC for continuation of services.
- 11.3.7. If the Participant requests a hearing, the Contractor shall provide to HCA and the enrollee, upon request, and within three (3) working days, all Contractor-held documentation related to the appeal.
- 11.3.8. The Contractor is an independent party and is responsible for its own representation in any administrative hearing, subsequent review process, and judicial proceedings.
- 11.3.9. If a final order, as defined in WAC 182-526-0010, reverses a Contractor decision to deny, limit, or delay health home services that were not provided while the appeal was pending, the Contractor shall authorize or provide the disputed health home services promptly.

12. STATEMENT OF WORK

- 12.1. **General Requirements:** The Contractor shall provide a community-based, integrated, Health Home program, based on the services detailed in Section 1945(h)(4) of the Social Security Act. The Contractor is responsible for the integration and coordination of primary, acute, behavioral health (mental health and substance use disorder) and long-term services and supports for eligible beneficiaries with chronic illness across the lifespan.
 - 12.1.1. The Contractor shall maintain a toll-free line and customer service representatives to answer Beneficiary questions regarding Health Home enrollment, disenrollment and how to access services or request a change of assignment to another Care Coordination Organization or a different Qualified Health Home, with minimum coverage 8:00 am to 5:00 pm from Monday to Friday.
 - 12.1.2. The Contractor shall ensure a system is in place to provide Beneficiaries with 24-hour emergency consultation.
 - 12.1.3. The Contractor shall provide interventions that address the Beneficiary's medical, social, economic, behavioral health, functional impairment, cultural and environmental factors affecting health and health care choices.
 - 12.1.4. The Contractor shall ensure a system is in place to track and share

Beneficiary information and care needs across providers. The tracking system shall be used to monitor processes of care and outcomes, and to initiate recommended changes in care necessary for Beneficiaries to achieve health action goals.

- 12.1.5. The Contractor shall ensure Health Home Services are provided in a culturally competent manner and addresses health disparities through:
 - 12.1.5.1. Direct interaction with the Beneficiary and his or her family in the Beneficiary's primary language;
 - 12.1.5.2. Recognizing cultural differences when developing the Health Action Plan (HAP) and administering screenings;
 - 12.1.5.3. Understanding the dynamics of substance use disorder and mental health conditions without judgment;
 - 12.1.5.4. Recognizing obstacles faced by persons with developmental, intellectual, cognitive or functional disabilities and helping them and their caregivers address those obstacles.
- 12.1.6. The Contractor shall maintain Memorandums of Understanding (MOUs) with organizations that authorize Medicaid services to ensure sharing of critical Beneficiary information and continuity of care is achieved. MOUs must contain information related to Beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable.
- 12.1.7. The Contractor shall maintain MOUs or working agreements with hospitals and skilled nursing facilities for transitioning care and referring eligible Beneficiaries for Health Home Enrollment.
- 12.2. **Subcontracting:** The Contractor shall maintain a network of subcontracted Care Coordination Organizations and other community entities sufficient in quantity and type to provide the Health Home Services appropriate to the needs of their enrolled population.
 - 12.2.1. Prior to receiving Beneficiary assignments, the Contractor shall ensure adequacy of subcontracted staff resources, including an assessment of staff skills and abilities to provide care management services to Beneficiaries."
 - 12.2.2. Subcontracts shall include the following elements:
 - 12.2.2.1. Payment methodology, including how administration of the subcontract will be paid;
 - 12.2.2.2. Required documentation, such as detailed logs of Health Home services rendered and who provided those services, such as the Care Coordinator or affiliated staff;
 - 12.2.2.3. A grievance process that complies with Section 11 of this Contract;

- 12.2.2.4. Incident reporting requirements that comply with Section 12.6.6 of this contract;
 - 12.2.2.5. Data use agreement terms and conditions;
 - 12.2.2.6. The terms and conditions specified in Section 9, Data Sharing which, by their sense and context, are intended to ensure client confidentiality and data security;
 - 12.2.2.7. Provisions for secure PRISM access;
 - 12.2.2.8. Provisions for completion of mandatory staff training requirements;
 - 12.2.2.9. Provisions for enhanced access to care provided through alternative hours of care, 24-7 access or nurse call centers that facilitate both appropriate use of services and receipt of evidence-based preventive and illness care.
 - 12.2.2.10. Provisions for the use of evidence-based practices and guidelines;
 - 12.2.2.11. Provisions to establish relationships with home care providers and community resources to facilitate the care of the Beneficiary; and
 - 12.2.2.12. Provisions to establish relationships with emergency departments, urgent care units, hospital, and long term care facilities that support timely sharing of information about services accessed; and which promotes transitional health care services.
 - 12.2.2.13. Provisions requiring use of the six defined Health Home Services, including the roles and responsibilities for Health Home Care Coordinators.
- 12.3. **Policies and Procedures:** The Contractor shall abide by all HCA policies and procedures for Health Home services, and maintain regularly updated Contractor-specific policies and procedures that address the following:
- 12.3.1. The Contractor's and subcontractor's roles and responsibilities for Beneficiary engagement;
 - 12.3.2. Beneficiary agreement to participate in Health Home Services;
 - 12.3.3. Identification and actions to mitigate Beneficiary gaps in care, including:
 - 12.3.3.1. Assessment of existing data sources (e.g. PRISM, CARE, etc.) for evidence of standards of care and prevention appropriate to the Beneficiary's age and underlying chronic conditions;
 - 12.3.3.2. Evaluation of Beneficiary perception of gaps in care,
 - 12.3.3.3. Documentation of gaps in care Beneficiary case file,
 - 12.3.3.4. Documentation of interventions in the HAP and progress notes,

- 12.3.3.5. Documentation of findings of the Beneficiary's response to interventions,
- 12.3.3.6. Documentation of follow-up actions, and the person or organization responsible for follow-up,
- 12.3.4. Care coordination activities that include:
 - 12.3.4.1. Maintaining direct contact between the Beneficiary and the Health Home Care Coordinator when delivering intensive care coordination services;
 - 12.3.4.2. Ensuring availability of support staff to complement the work of the care coordinator;
 - 12.3.4.3. Screening, referral and co-management of individuals with behavioral health, long term services and supports and physical health conditions;
 - 12.3.4.4. Ensuring an appointment reminder system is in place for beneficiaries;
 - 12.3.4.5. Tracking of Beneficiary assignment to Care Coordination Organizations;
- 12.3.5. Referrals to HCA for eligibility review of any potential Beneficiary who seeks or needs Health Home Services, for example:
 - 12.3.5.1. Overuse of preventable emergency department services,
 - 12.3.5.2. No apparent primary health care,
 - 12.3.5.3. Opioid prescription use exceeding 120 morphine milligram equivalents per day,
 - 12.3.5.4. Inconsistent medication prescribing or refills for the management of chronic disease,
 - 12.3.5.5. Frequent hospitalizations and/or preventable hospital readmissions,
 - 12.3.5.6. Underuse of preventive care,
 - 12.3.5.7. Underuse of services considered standard for treatment of chronic conditions, such as diabetes, cardiovascular disease or serious and persistent mental illness;
- 12.3.6. Transferring care from hospitals and emergency departments;
- 12.3.7. A grievance system that complies with the requirements of this Contract;
- 12.3.8. Critical incident reporting that complies with the requirements of this Contract.

12.3.9. The Contractor shall have an established and documented policy to deal with the compromise or potential compromise of Data that complies with the HITECH Act of ARRA 2009.

12.4. **Written Beneficiary Materials:** The Contractor shall provide all written Beneficiary materials developed by the Contractor or any subcontractor in a language and format which may be understood the Beneficiary.

12.4.1. If five percent (5%) or more of the Contractor's Health Home Beneficiaries speak a specific language other than English, written materials shall be translated into that language.

12.4.2. For Beneficiaries whose language needs are not addressed by translating written materials as required in Section 12.4.1 of this contract, the Contractor shall provide and document the use one of the following alternatives when requested by the Beneficiary or the Beneficiary's authorized representative:

12.4.2.1. Translating the material into the Beneficiary's primary reading language;

12.4.2.2. Providing the material in an audio format in the Beneficiary's primary language;

12.4.2.3. Having an interpreter read the material to the Beneficiary in the Beneficiary's primary language;

12.4.2.4. Providing the material in another alternative medium or format acceptable to the Beneficiary;

12.4.2.5. Providing the material in English, if the Contractor documents the Beneficiary's preference for receiving material in English;

12.4.3. The Contractor shall ensure that all written information provided to Beneficiaries is written at the sixth grade reading level, is accurate, and not misleading.

12.4.4. HCA may make exceptions to the sixth grade reading level when, in the sole judgment of HCA, the nature of the materials do not allow for a sixth grade reading level or the Beneficiary's needs are better served by allowing a higher reading level. HCA approval of exceptions to the sixth grade reading level must be in writing.

12.4.5. Educational materials about topics such as Disease Management preventative services or other information used by the Contractor for health promotion efforts that are not developed by the Contractor or developed under contract with the Contractor are not required to meet the sixth grade reading level requirement.

12.4.6. The Contractor shall submit all written Beneficiary material developed by the Contractor or any of its subcontractors to HCA for review and approval prior to distribution.

12.5. Training Requirements: The Contractor shall comply with the training requirements of this Section.

- 12.5.1. The Contractor shall ensure that authorized personnel and affiliated staff complete client confidentiality and data security training upon hire and annually thereafter.
- 12.5.2. The Contractor shall ensure that Health Home Care Coordinators complete the State-approved Health Home Care Coordinator training prior to providing Health Home Services.
- 12.5.3. The Contractor shall ensure that Health Home Care Coordinators complete the following special-topic modules through State-sponsored classroom training or using State-developed training materials published on the DSHS website within six (6) months of hire.
 - 12.5.3.1. Outreach and Engagement Strategies;
 - 12.5.3.2. Navigating the LTSS System: Part 1;
 - 12.5.3.3. Navigating the LTSS System: Part 2;
 - 12.5.3.4. Cultural and Disability Competence Considerations;
 - 12.5.3.5. Assessment Screening Tools,
 - 12.5.3.6. Medicare Grievances and Appeals;
 - 12.5.3.7. Coaching and Engaging Clients with Mental Health Needs.
- 12.5.4. The Contractor shall ensure that authorized and affiliated personnel comply with continued training requirements as necessary.
- 12.5.5. The Contractor shall ensure that evidence of satisfactory completion of training requirements is maintained in the appropriate personnel records.
 - 12.5.5.1. The Contractor shall have a Health Home Care Coordinator trainer on staff, or shall subcontract for Health Home Care Coordinator training services.
 - 12.5.5.2. The trainer shall be certified by DSHS prior to providing Health Home Care Coordinator training.
 - 12.5.5.3. Certification of the trainer includes:
 - 12.5.5.3.1. Completion of the Health Home Care Coordinator training course;
 - 12.5.5.3.2. Completion of a State-sponsored trainers preparation course;
 - 12.5.5.3.3. Satisfactory delivery of a Health Home Care Coordinator training observed by DSHS;

- 12.5.5.3.4. Receipt of a State-issued certificate of completion or letter authorizing the individual to provide training to Health Home Care Coordinators.
- 12.5.5.4. The Contractor shall ensure that the trainer uses and maintains fidelity to the State-developed Training Manual for Health Home Care Coordinators.
 - 12.5.5.4.1. The Contractor shall ensure that Health Home care coordinator training is delivered using all of the DSHS materials including the PowerPoint Presentation, small group activities, training agenda, and training manual inserts, and handouts.
 - 12.5.5.4.2. The Contractor shall ensure that the trainer does not change, alter, or modify the State-approved Health Home Care Coordinator training, activities, curriculum or materials.
 - 12.5.5.4.3. The Contractor shall ensure that the trainer does not include unauthorized topics, curriculum, or material in the Health Home Care Coordinator training.
- 12.6. **Eligibility and Enrollment:** HCA will determine eligibility for the Health Home program and passively enroll eligible Beneficiaries with the Contractor.
 - 12.6.1. Beneficiaries deemed eligible by HCA for the Health Home program shall have at least one chronic condition, and be at risk of a second as determined by a minimum predictive risk score of 1.5.
 - 12.6.1.1. The chronic conditions covered for eligibility are:
 - 12.6.1.1.1. Mental health conditions;
 - 12.6.1.1.2. Substance use disorders;
 - 12.6.1.1.3. Asthma;
 - 12.6.1.1.4. Diabetes;
 - 12.6.1.1.5. Heart disease;
 - 12.6.1.1.6. Cancer;
 - 12.6.1.1.7. Cerebrovascular disease;
 - 12.6.1.1.8. Coronary artery disease;
 - 12.6.1.1.9. Dementia or Alzheimer's disease;
 - 12.6.1.1.10. Intellectual disability or disease;
 - 12.6.1.1.11. HIV/AIDS;

- 12.6.1.1.12. Renal failure;
 - 12.6.1.1.13. Chronic respiratory conditions;
 - 12.6.1.1.14. Neurological disease;
 - 12.6.1.1.15. Gastrointestinal disease;
 - 12.6.1.1.16. Hematological conditions;
 - 12.6.1.1.17. Musculoskeletal conditions.
- 12.6.2. The Contractor shall accept referrals for Health Home Services from any healthcare or social service professional, whether or not the individual is contracted to provide services on behalf of the Contractor.
- 12.6.2.1. The Contractor shall complete and submit the Clinical Eligibility Tool to HCA for Beneficiaries that have been referred for Health Home services, or that have less than fifteen (15) months of claims history.
 - 12.6.2.2. HCA shall determine eligibility criteria and final authorization of Health Home Services.
 - 12.6.2.3. If a Beneficiary meets all eligibility criteria, HCA shall update its records and enroll the Beneficiary into the most appropriate Qualified Health Home.
- 12.7. **Care Coordination Organization (CCO) Assignment:** Contractor shall ensure eligible Health Home Beneficiaries receive Health Home Services through one of its subcontracted CCOs using a smart assignment process that takes into account the Beneficiary's preferred provider(s). This shall be achieved by:
- 12.7.1. Using PRISM or other data systems to match the Beneficiary to the CCO that provides most of the Beneficiary's needed services;
 - 12.7.2. Providing the Beneficiary the option to choose a CCO.
 - 12.7.3. Upon the Beneficiary's request, the Contractor shall transfer care coordination assignment to another of its subcontracted CCOs.
- 12.8. **Beneficiary Engagement:** The Contractor shall ensure that the CCO to which the Beneficiary is assigned attempts contact with the Beneficiary to offer Health Home services within ten (10) calendar days after Health Home Care Coordination Assignment.
- 12.8.1. The Contractor shall ensure the CCO maintains a Beneficiary contact log documenting the purpose of the contact and identifying staff that interacts with the Beneficiary.
 - 12.8.2. The Contractor shall provide Beneficiaries with the option to decline to participate in the Health Home program at any time.

- 12.8.3. The Contractor shall allow Beneficiaries who decline to participate in the Health Home program to re-enroll at any time in accordance with the HCA's enrollment rules.
- 12.9. **Health Action Plan (HAP):** The Contractor shall ensure that HAPs are completed within ninety (90) days from the date of the Beneficiary's Health Home Enrollment.
 - 12.9.1. The Contractor shall ensure that the Health Home Care Coordinator meets in person with each Beneficiary at the Beneficiary's choice of location to explain, develop, and complete the HAP.
 - 12.9.1.1. HAPs shall be developed with input from the Beneficiary and/or the Beneficiary's caregiver(s).
 - 12.9.1.2. HAPs shall be developed with consideration of the Beneficiary's medical record, PRISM data, treatment plans, CARE assessments, previous screens and assessments if available.
 - 12.9.1.3. HAPs shall document the Beneficiary's diagnosis, long term goals, short term goals, and related action steps to achieve those goals.
 - 12.9.1.4. HAPs shall include the required BMI, Katz ADL, and PHQ-9 screening scores.
 - 12.9.1.5. HAPs shall include the Patient Activation Measure (PAM), or Caregiver Activation Measure (CAM) screening level and score.
 - 12.9.1.6. HAPs shall identify whether optional screenings were administered
 - 12.9.2. HAPs shall be reviewed and updated by the Health Home Care Coordinator at a minimum:
 - 12.9.2.1. Every four (4) months to update the PAM, CAM, BMI, Katz ADL, and PHQ-9 screening scores and reassess the Participant's progress towards meeting self-identified health action goals, add new goals, or change in current goals;
 - 12.9.2.2. Whenever there is a change in the Participant's health status, or a change in the Participant's needs or preferences.
 - 12.9.3. Completed and updated HAPs shall be submitted to HCA through the OneHealthPort Health Information Exchange; and shall be preserved in the Contractor's local records for evaluation purposes.
 - 12.9.4. Completed and updated HAPs shall be shared with Participants in a State-approved format, using language that is understandable to the Beneficiary and/or the Beneficiary's caregiver(s).
 - 12.9.5. Completed and updated HAPs shall be shared with other individuals identified by the Participant. These individuals include, but are not limited to family, caregivers, primary care providers, mental health treatment providers,

and authorizers of long term services and supports and/or chemical dependency treatment providers.

12.10. Comprehensive Care Management: The Contractor shall ensure the CCO provides Comprehensive Care Management interventions that recognize and are tailored to the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors impacting the Participant's health and health care choices.

12.10.1. Comprehensive Care Management caseloads shall allow staff to ensure continuity of care and provide timely care management interventions including:

12.10.1.1. Assessing Participant readiness for self-management, promotion of self-management skills, and progress toward achieving health action goals;

12.10.1.2. Promoting participation in improving self-management skills and clinical outcomes;

12.10.1.3. Facilitating achievement of self-directed health action goals designed to attain recovery, improve functional status, or prevent or slow declines in functioning;

12.10.1.4. Resolving any barriers to achieving health action goals;

12.10.1.5. Enabling access to peer supports, support groups and self-care programs to increase the Participant's knowledge about his or her health care conditions and improve adherence to prescribed treatment;

12.10.1.6. Ensuring Participants are accompanied when necessary to critical health care and social service appointments to assist the Participant in achieving his or her health action goals.

12.10.2. The Health Home Care Coordinator shall routinely reassess the Participants activation level to determine the appropriate coaching methodology and develop a teaching and support plan that includes:

12.10.2.1. Introduction of customized educational materials according to the Participant's readiness for change;

12.10.2.2. Progression of customized educational materials in combination with the Participant's level of confidence and self-management abilities;

12.10.2.3. Documentation of wellness and prevention education specific to the Participant's chronic conditions, including assessment of need and facilitation of routine preventive care, support for improving social connections to community networks, and linking the Beneficiary with resources that support a health promoting lifestyle;

- 12.10.2.4. Documentation of opportunities for mentoring and modeling communication with health care providers provided through joint office visits and communications with health care providers by the Participant and the Health Home Care Coordinator;
- 12.10.2.5. Links to resources for, but not limited to, smoking prevention and cessation, substance use disorder prevention, nutritional counseling, obesity reduction and prevention, increasing physical activity, disease specific or chronic care management self-help resources, and other services, such as housing based on individual needs and preferences.

12.11. Care Coordination and Health Promotion: The Health Home Care Coordinator shall develop and execute cross-system care coordination activities to assist Participants in accessing and navigating needed services.

12.11.1. The Contractor shall ensure the Health Home Care Coordinator has primary responsibility for the Beneficiary's care coordination.

12.11.1.1. Collaboration shall be facilitated with Multidisciplinary Teams of health care professionals such as primary care providers, mental health professionals, chemical dependency treatment providers and social workers to address the full breadth of clinical and social service needs for individuals with complex chronic conditions, mental health and substance use disorder issues and who need for long term services and supports.

12.11.1.1.1. Multidisciplinary Team members shall have access to or be providers from the local community that authorize Medicaid, state or federally funded mental health, long-term services and supports (including the direct care workforce), chemical dependency and medical services. This group may include Regional Support Networks (RSNs), Home and Community Services (HCS), Community Mental Health Agencies (CMHAs), Area Agencies on Aging (AAAs), Substance Abuse Disorder Providers and community supports that assist with housing.

12.11.1.1.2. Optional Multidisciplinary Team members may include nutritionist/dieticians, direct care workers, pharmacists, peer specialists, family members and housing representatives.

12.11.1.2. Effective and timely communication shall be maintained with Multidisciplinary Team members and entities authorizing Medicaid services in order to discuss any changes in Participant circumstances, condition, or HAP.

12.11.1.3. Direct care providers, paid and unpaid, who have a role in supporting the Participant shall be leveraged to help achieve health action goals and access health care services.

12.11.1.4. Communication, coordination, and care management functions shall not be duplicated between the CCO and Medicaid case managers involved in the Participant's care, including DSHS case managers.

12.11.1.5. Care coordination activities and communication shall be documented in the Participant's record of services.

12.12. Comprehensive Transitional Care: The Contractor shall ensure the CCO provides comprehensive transitional care to prevent avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing, substance use disorder treatment or residential habilitation setting) and to ensure proper and timely follow-up care.

12.12.1. Transitional care planning includes:

12.12.1.1. A notification system between managed care organizations, hospitals, nursing facilities and residential/rehabilitation facilities that provide prompt notification of a Participant's admission or discharge from an emergency room, inpatient setting, nursing facility or residential/rehabilitation, and if proper permissions are in place, a substance use disorder treatment setting;

12.12.1.2. Participation by the Health Home Care Coordinator in all phases of care transition, including discharge planning visits during hospitalizations or nursing home stays post hospital/institutional stay, home visits and follow-up telephone calls;

12.12.1.3. Participation of formal or informal caregivers as requested by the Participant;

12.12.1.4. Documented review of medication reconciliation, management, and monitoring;

12.12.1.5. Communication of Hallmark Events to the assigned Health Home Care Coordinator;

12.12.1.6. Participant education that supports discharge care needs including medication management, encouragement and intervention to assure follow-up appointments are attended, and follow-up for self-management of chronic or acute conditions, including information on when to seek medical care and emergency care;

12.12.1.7. Follow-up protocols to identify and engage Participants that do not receive post discharge care;

12.12.1.8. Progress notes or a case record that documents all communication and transition activity;

12.12.2. The Contractor may employ staff that have been trained and hired specifically to provide transitional services, as long as the Health Home

Care Coordinator is an active participant in all phases of the transitional planning process.

- 12.12.3. The Contractor shall ensure that transitional care services rendered under this Contract do not duplicate those provided by other organizations funded to provide care transition.
- 12.13. **Individual and Family Supports:** The Contractor shall ensure the Health Home Care Coordinator involves individual and family supports in care coordination, care management, and transitional care activities, including:
 - 12.13.1. Identification of the role that families, informal supports and paid caregivers provide to achieve the Participant's self-management and optimal levels of physical and cognitive function;
 - 12.13.2. Education and support of self-management, self-help, recovery, and other resources necessary to achieve the Participant's health action goals;
 - 12.13.3. Documentation and discussion of advance directives;
 - 12.13.4. Communication and information sharing with the Participant's family and other caregivers with appropriate consideration of language, activation level, literacy, and cultural preferences.
- 12.14. **Referrals to Community and Social Support Services:** The Contractor shall ensure the Health Home Care Coordinator identifies, refers, and facilitates access to relevant community and social support services that support the Participant's health action goals.
 - 12.14.1. Referrals shall be made to coordinate services with appropriate departments of local, state, and federal governments, as well as with community-based resources.
 - 12.14.2. Referrals to community resources shall include long-term services and supports, mental health, substance use disorder, and other community and social supports;
 - 12.14.3. Referrals to community resources shall be documented in the Participant's service record and as appropriate in the HAP;
 - 12.14.4. Assistance shall be provided for the Participant to obtain and maintain eligibility for health care services, disability benefits, housing, and legal services not provided through other case management systems.
- 12.15. **Access and Use of Health Information Technology:** The Contractor and subcontracted CCO network of providers shall use available health information technology (HIT) and access data available from Medicaid managed care organizations or Fee-for-Service systems.
 - 12.15.1. The Contractor shall ensure the subcontracted CCO network of providers:

- 12.15.1.1. Uses HIT to identify and support management of high risk Beneficiaries in care management;
 - 12.15.1.2. Uses conferencing audio, video and/or web deployed solutions to support case consultation and team-based care when security protocols and precautions are in place to protect Protected Health Information (PHI);
 - 12.15.1.3. Uses HIT to track and share Beneficiary information and care needs across providers, to monitor processes of care and outcomes, and to initiate changes in care as necessary;
 - 12.15.1.4. Uses HIT registries and referral tracking systems to facilitate coordination and inform treatment providers;
 - 12.15.1.5. Tracks service utilization and quality indicators and provides timely and actionable information to Health Home Care Coordinator regarding under, over, or inappropriate utilization patterns;
 - 12.15.1.6. Develops a system with hospitals, nursing Home and residential/rehabilitation facilities to provide the CCO prompt notification of a Participant's admission to and/or discharge from an emergency room, inpatient, or residential/rehabilitation setting;
 - 12.15.1.7. Develops methods to communicate real-time use of emergency room, inpatient hospitalizations, missed prescription refills and the need for evidence-based preventive care to care coordination staff;
 - 12.15.1.8. Uses the Emergency Department Information Exchange (EDIE) when necessary.
- 12.16. **Reporting Requirements:** The Contractor shall maintain the ability to collect, report, and share data and information with HCA, DSHS, and affiliated providers of Health Home Services.
- 12.16.1. **Encounter Data Submission:** The Contractor shall submit electronic encounter data to HCA for payment in accordance with the HCA Encounter Data Reporting Guide.
- 12.16.1.1. The Contractor shall submit encounter data for individual Participants based upon provision of eligible Health Home Services.
 - 12.16.1.2. The Contractor shall incorporate any changes made by HCA to the Encounter Data Reporting Guide no later than 150 days from the date of change.
- 12.16.2. **Monthly Encounter Reports:** The Contractor shall submit a monthly encounter report to HCA within fifteen (15) calendar days after the end of the month.

- 12.16.2.1. Monthly encounter reports shall be submitted on a standardized Excel spreadsheet developed by HCA.
- 12.16.2.2. The Contractor shall incorporate any changes made by HCA to the Monthly Encounter Report format no later than 30 days from the date of change.
- 12.16.3. **Quarterly Quality Reports:** The Contractor shall submit quality to HCA every three (3) months in accordance with the following reporting periods:
 - 12.16.3.1. January through March due May 1;
 - 12.16.3.2. April through June due August 1;
 - 12.16.3.3. July through September due November 1;
 - 12.16.3.4. October through December due February 1.
 - 12.16.3.4.1. Quarterly quality reports must contain the following narrative elements:
 - 12.16.3.4.1.1. Executive Summary of Health Home Service provided during the reporting period;
 - 12.16.3.4.1.2. Individual Beneficiary outreach and engagement success stories for higher risk groups (PRISM score of 4.0 or higher) for two (2) Beneficiaries;
 - 12.16.3.4.1.3. Barriers that inhibit success of the program;
 - 12.16.3.4.2. Quarterly quality reports need to contain the following data elements:
 - 12.16.3.4.2.1. Number of Assignments made to each subcontracted CCO;
 - 12.16.3.4.2.2. Number of completed Health Action Plans;
 - 12.16.3.4.2.3. Number of Beneficiary short-term goals completed;
 - 12.16.3.4.2.4. Number of Beneficiary long-term goals completed.
- 12.16.4. **Subcontracted CCOs:** Within 30 days from the start of this Contract and on May 15th of each succeeding year, the Contractor shall submit a complete list of subcontracted CCOs in a format developed by HCA.
 - 12.16.4.1. The list shall include each subcontracted CCOs name and address, contact information, date subcontract was executed, counties served, service specialties, number of Health Home Care Coordinators, and number of other dedicated Health Home staff.

12.16.4.2. The Contractor shall incorporate any changes made by HCA to the Subcontracted CCOs report format no later than 30 days from the date of change.

12.16.5. **Incident Reports:** The Contractor shall have a designated incident manager responsible for meeting the requirements of this section.

12.16.5.1. The Contractor shall report all instances of suspected abuse, abandonment, neglect and/or exploitation of Beneficiaries to 1-866-END-HARM.

12.16.5.2. The Contractor shall report the following incidents to HCA within one (1) business day of becoming aware of their occurrence:

12.16.5.2.1. Any injury to the Beneficiary requiring action by the Health Home Care Coordinator to ensure emergency medical care is provided;

12.16.5.2.2. Any mental health crisis that occurs in the presence of the Health Home Care Coordinator requiring intervention by law enforcement or medical personnel;

12.16.5.2.3. Any event involving a credible threat towards the Health Home Care Coordinator or affiliated staff. A credible threat is defined as "a communicated intent (veiled or direct) in either words or actions of intent to cause bodily harm and/or personal property damage to a staff member or a staff member's family.

12.16.5.3. The Contractor shall report incidents in the format developed by HCA.

12.16.5.4. The Contractor shall incorporate any changes made by HCA to the Incident Report format no later than 30 days from the date of change.

12.16.5.5. HCA or DSHS may require the Contractor to initiate a comprehensive review of an incident.

12.16.5.6. The Contractor shall fully cooperate with any investigation initiated by HCA or DSHS and shall provide requested information within the timeframes specified.

12.16.5.7. DSHS and HCA have the authority to obtain information directly from any involved provider or party;

12.16.5.8. An incident shall be considered unresolved until the following information is provided:

12.16.5.8.1. A summary of any incident debriefings or review process dispositions;

- 12.16.5.8.2. The present physical location of the Beneficiary if known. If the Beneficiary cannot be located, the Contractor shall document the steps that the Contractor took to attempt to locate the Beneficiary by using available local resources;
- 12.16.5.8.3. Documentation of whether the Beneficiary is receiving or not receiving Health Home Services from the Contractor at the time the incident is being closed.

Exhibit A: Non-Disclosure of HCA Confidential Information

CONFIDENTIAL INFORMATION

As an employee of United Behavioral Health, which is doing business with the Washington State Health Care Authority under Client Services Contract No. K893, you may be given access to or come into contact with HCA's or HCA's business partner's records and information that are deemed private and confidential by statute. Confidential information includes, but is not limited to, names, social security numbers, individual protected health information (PHI), client names, services or benefits and any other information identifying individual clients that is protected by law and not available to the general public.

I understand:

1. The requirements of this Client Services Contract for protecting confidential information;
2. The penalties and sanctions associated with unauthorized information access or disclosure; and
3. My responsibilities to keep confidential information and computer systems secure, as explained in this Client Services Contract.

REQUIREMENTS AND PENALTIES

State laws applicable to Department programs (including RCW 74.04.060, Chapter 13.50 RCW; and Chapter 70.02 RCW) and federal regulations (including HIPAA Privacy and Security Rules; the Social Security Act, and chemical dependency rules at 42 CFR, Part 2) prohibit unauthorized access, use, or disclosure of confidential information. Civil penalties for violations of HIPAA Privacy and Security Rules may be imposed of up to \$50,000 per violation up to a total \$1,500,000 for violations of a requirement during a calendar year. Criminal penalties may total up to \$250,000 and ten years imprisonment.

EMPLOYEE ASSURANCE OF CONFIDENTIALITY

As an employee of United Behavioral Health, I commit and agree to be bound by the following:

1. I certify not to access or use confidential information unless directly related to my assigned job duties and agree to protect information as required by law and this Client Services Contract.
2. I certify not to disclose confidential information to any unauthorized person or entity, either orally, in writing, or by electronic means, not to use confidential information for personal purposes or gain.
3. I understand that I am authorized to access, use and/or disclose only the "minimum necessary" confidential information required to perform my assigned job duties.
4. I understand that I am not authorized to store confidential information on personal devices or systems not provided by my employer and authorized by HCA.
5. I understand that it is my responsibility to report any and all suspected or actual unauthorized access, loss, theft, or disclosure of confidential information.
6. If I have questions or am uncertain about requests for confidential information that I may receive, I will forward them to my supervisor for resolution.
7. I understand that these requirements and my assurance of confidentiality do not cease at the time my employment ends with United Behavioral Health

FREQUENCY OF EXECUTION AND DISPOSITION INSTRUCTIONS

This form will be executed by each employee and updated annually during the term of this Contract. Provide the employee with a copy of this form and retain the original of each signed form in the employee's personnel file for a minimum of six years.

SIGNATURE

PRINT EMPLOYEE'S NAME	EMPLOYEE'S SIGNATURE	DATE
PRINT SUPERVISOR'S NAME	SUPERVISOR'S SIGNATURE	DATE

Exhibit B: Federal Compliance, Certification, and Assurances

In the event federal funds are included in this Agreement, the following sections apply: I. Federal Compliance and IV, Standard Federal Assurances and Certifications. In the instance of inclusion of federal funds, the Contractor may be designated as a sub-recipient and the effective date of the amendment shall also be the date at which these requirements go into effect.

I. **FEDERAL COMPLIANCE** - The use of federal funds requires additional compliance and control mechanisms to be in place. The following represents the majority of compliance elements that may apply to any federal funds provided under this Contract. For clarification regarding any of these elements or details specific to the federal funds in this Contract, contact: The Health Home Program Manager.

- a. *Source of Funds:* Federal funds to support this Contract are identified by the Catalog of Federal Domestic Assistance (CFDA) number 93.778. The sub-recipient is responsible for tracking and reporting the cumulative amount expended under HCA Client Service Contract No. K893.
- b. *Single Audit Act:* A contractor who is a sub-recipient (including private, for-profit hospitals and non-profit institutions) shall adhere to the federal Office of Management and Budget (OMB) Circular A-133, as well as all applicable federal and state statutes and regulations. A contractor who is a sub-recipient who expends \$500,000 or more in federal awards during a given fiscal year shall have a single or program-specific audit for that year in accordance with the provisions of OMB Circular A-133.
- c. *Modifications:* This Contract may not be modified or amended, nor may any term or provision be waived or discharged, including this particular Paragraph, except in writing, signed upon by both parties.
 1. Examples of items requiring Health Care Authority prior written approval include, but are not limited to, the following:
 - i. Deviations from the budget and Project plan.
 - ii. Change in scope or objective of this Contract.
 - iii. Change in a key person specified in this Contract.
 - iv. The absence for more than three months or a 25% reduction in time by the Project Manager/Director.
 - v. Need for additional funding.
 - vi. Inclusion of costs that require prior approvals as outlined in the appropriate cost principles.
 - vii. Any changes in budget line item(s) of greater than twenty percent (20%) of the total budget in this Contract.
 2. No changes are to be implemented by the Contractor/Sub-recipient until a written notice of approval is received from the Health Care Authority.

Exhibit B: Federal Compliance, Certification, and Assurances

- d. *Condition for Receipt of Health Care Authority Funds:* Funds provided by Health Care Authority to the Contractor/Sub-recipient under this Contract may not be used by the Contractor/Sub-recipient as a match or cost-sharing provision to secure other federal monies.
- e. *Unallowable Costs:* The Contractor's/Sub-recipients' expenditures shall be subject to reduction for amounts included in any invoice or prior payment made which determined by HCA not to constitute allowable costs on the basis of audits, reviews, or monitoring of this Contract.
- f. *Citizenship/Alien Verification/Determination:* The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (PL 104-193) states that federal public benefits should be made available only to U.S. citizens and qualified aliens. Contractors/Sub-recipients that offer a service defined as a "federal public benefit" must make a citizenship/qualified alien determination/ verification of applicants at the time of application as part of the eligibility criteria. Non-US citizens and unqualified aliens are not eligible to receive the services. PL 104-193 also includes specific reporting requirements.
- g. *Federal Compliance:* The Contractor/Sub-recipient shall comply with all applicable State and Federal statutes, laws, rules, and regulations in the performance of this Contract, whether included specifically in this Contract or not.
- h. *Civil Rights and Non-Discrimination Obligations* During the performance of this Contract, the Contractor/Sub-recipient shall comply with all current and future federal statutes relating to nondiscrimination. These include but are not limited to: Title VI of the Civil Rights Act of 1964 (PL 88-352), Title IX of the Education Amendments of 1972 (20 U.S.C. §§ 1681-1683 and 1685-1686), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), the Age Discrimination Act of 1975 (42 U.S.C. §§ 6101-6107), the Drug Abuse Office and Treatment Act of 1972 (PL 92-255), the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (PL 91-616), §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290dd-3 and 290ee-3), Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), and the Americans with Disability Act (42 U.S.C., Section 12101 et seq.)
<http://www.hhs.gov/ocr/civilrights>

HCA Federal Compliance Contact Information

Becky McAninch-Dake, Health Home Program Manager
Washington State Health Care Authority
Post Office Box 45530
Olympia, Washington 98504-5530

Exhibit B: Federal Compliance, Certification, and Assurances

II. CIRCULARS 'COMPLIANCE MATRIX' - The following compliance matrix identifies the OMB Circulars that contain the requirements which govern expenditure of federal funds. These requirements apply to the Washington State Health Care Authority (HCA), as the primary recipient of federal funds and then follow the funds to the Contractor/Sub-recipient. The federal Circulars which provide the applicable administrative requirements, cost principles and audit requirements are identified by sub-recipient organization type.

III.

ENTITY TYPE	OMB CIRCULAR		
	ADMINISTRATIVE REQUIREMENTS	COST PRINCIPLES	AUDIT REQUIREMENTS
State, Local and Indian Tribal Governments and Governmental Hospitals	A-102 & Common Rule	A-87	A-133
Non-Profit Organizations and Non-Profit Hospitals	A-110	A-122	A-133
Colleges or Universities and Affiliated Hospitals	A-110	A-21	A-133
For-Profit Organizations	A-110	48 CFR 31.2	Requirements established by the pass-through entity, pursuant to A-133, §.210(e)

*Definitions:

"Sub-recipient"; means the legal entity to which a sub-award is made and which is accountable to the State for the use of the funds provided in carrying out a portion of the State's programmatic effort under a sponsored project. The term may include institutions of higher education, for-profit corporations or non-U.S. based entities.

"Sub-award and Sub-grant" are used interchangeably and mean a lower tier award of financial support from a prime awardee (e.g., Washington State Health Care Authority) to a contractor/sub-recipient for the performance of a substantive portion of the program. These requirements do not apply to the procurement of goods and services for the benefit of the Washington State Health Care Authority.

IV. STANDARD FEDERAL CERTIFICATIONS AND ASSURANCES - Following are the Assurances, Certifications, and Special Conditions that apply to all agreements administered by the Washington State Health Care Authority that are paid for, in whole or in part, with federal funds.

Exhibit B: Federal Compliance, Certification, and Assurances

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the Contractor) certifies to the best of his or her knowledge and belief, that the Contractor, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b) have not within a 3-year period preceding this Contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d) have not within a 3-year period preceding this Contract had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the Contractor not be able to provide this certification, an explanation as to why should be placed after the assurances page in this Contract.

The Contractor agrees by signing this Contract that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the Contractor) certifies that the Contractor will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- b) Establishing an ongoing drug-free awareness program to inform employees about
 - (1) The dangers of drug abuse in the workplace;
 - (2) The Contractor's policy of maintaining a drug-free workplace;
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

Exhibit B: Federal Compliance, Certification, and Assurances

c) Making it a requirement that each employee to be engaged in the performance of this Contract be given a copy of the statement required by paragraph (a) above;

d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the Contract, the employee will—

- (1) Abide by the terms of the statement; and
- (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e) Notifying the Agency in writing within ten calendar days after receiving notice under paragraph (d) (2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every contract officer or other designee on whose contract activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted—

- (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
- (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding Agency notification of criminal drug convictions, Authority has designated the following central point for receipt of such notices:

Legal Services Manager
WA State Health Care Authority
PO Box 42702
Olympia, WA 98504-2700

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the contracting organization) certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in

Exhibit B: Federal Compliance, Certification, and Assurances

connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

- (3) The undersigned shall require that the language of this certification be included in the award documents for all subcontracts at all tiers (including subcontracts, subcontracts, and contracts under grants, loans and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the Contractor) certifies that the statements herein are

true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the Contractor will comply with the Public Health Service terms and conditions of award if a contract is awarded.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the Contractor will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

Exhibit B: Federal Compliance, Certification, and Assurances

The Contractor agrees that it will require that the language of this certification be included in any subcontracts which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Public Health Services strongly encourages all recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

6. CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS INSTRUCTIONS FOR CERTIFICATION

- 1) By signing and submitting this proposal, the prospective contractor is providing the certification set out below.
- 2) The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. The prospective contractor shall submit an explanation of why it cannot provide the certification set out below. The certification or explanation will be considered in connection with the department or agency's determination whether to enter into this transaction. However, failure of the prospective contractor to furnish a certification or an explanation shall disqualify such person from participation in this transaction.
- 3) The certification in this clause is a material representation of fact upon which reliance was placed when the department or agency determined to enter into this transaction. If it is later determined that the prospective contractor knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency may terminate this transaction for cause of default.
- 4) The prospective contractor shall provide immediate written notice to the department or agency to which this Contract is submitted if at any time the prospective contractor learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
- 5) The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, proposal, and voluntarily excluded, as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549. You may contact the person to whom this contract is submitted for assistance in obtaining a copy of those regulations.
- 6) The prospective contractor agrees by submitting this Contract that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by Authority.
- 7) The prospective contractor further agrees by submitting this contract that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion -- Lower Tier Covered Transaction," provided by HHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
- 8) A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not

Exhibit B: Federal Compliance, Certification, and Assurances

required to, check the Non-procurement List (of excluded parties).

9) Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

10) Except for transactions authorized under paragraph 6 of these Instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, Authority may terminate this transaction for cause or default.

7. CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS -- PRIMARY COVERED TRANSACTIONS

1) The prospective contractor certifies to the best of its knowledge and belief, that it and its principals:

a) Are not presently debarred, suspended, proposed for debarment, declared ineligible,


or voluntarily excluded from covered transactions by any Federal department or agency; Have not within a three-year period preceding this contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

b) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (1)(b) of this certification; and

c) Have not within a three-year period preceding this contract had one or more public transactions (Federal, State or local) terminated for cause or default.

2) Where the prospective contractor is unable to certify to any of the statements in this certification, such prospective contractor shall attach an explanation to this proposal.

CONTRACTOR SIGNATURE REQUIRED

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL 	TITLE CFO
Please also print or type name: LESLIE J. DAVIS	
ORGANIZATION NAME: (if applicable) UNITED BEHAVIORAL HEALTH	DATE JULY 07, 2014

Attachment A: Part D WA State Data Use Agreement

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mailstop N1-24-08
Baltimore, Maryland 21244-1850



Cathie Ott
State of Washington
Health Care Authority
626 8th Avenue SE
Olympia, Washington 98504

Dear Ms. Ott:

Enclosed is a copy of the signed Data Use Agreement (DUA) and the Information Exchange Agreement that the Centers for Medicare & Medicaid Services (CMS) have entered into with your organization for the CMS/Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) program entitled, "Part D - Care Coordination for Beneficiaries Who are Dually Eligible in the Medicare/Medicaid Programs." Please refer to DUA number 21628 when addressing inquiries of any nature concerning this agreement.

I have also enclosed the CMS DUA Guidelines which outlines your responsibilities in terms of safeguarding the confidentiality of CMS data. This approval is based on the understanding that personnel within your organization and any subcontracting organization's personnel will comply with all requirements of this Agreement into which you have entered. It is your responsibility to provide a copy of this agreement and CMS DUA Guidelines to the individuals listed below for your organization and/or any subcontracting organization. Please emphasize the importance of complying with this agreement. Note that this approval only applies to this request for the study mentioned above. Any additional purpose will have to be reviewed and approved by CMS.

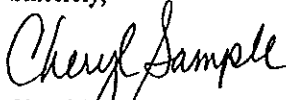
Please note that any organization requesting CMS data that has an EXPIRED CMS DUA will not receive authorization to obtain any new data until their expired DUA has been resolved. The retention date stipulates the timeframe in which the information can be used. If your DUA is about to expire, and your project is still in need of the CMS data, you will need to request an extension date on the DUA. However, if your study is complete and the data is no longer required, you must contact CMS and request that the DUA be closed by providing written certification that you have destroyed the CMS data. More information regarding the resolution of expired DUAs can be found at the following CMS website:
www.cms.hhs.gov/PrivProtectedData/ under "DUA Extensions or Destruction of CMS Data."

Attachment A: Part D WA State Data Use Agreement

Page 2

If you have any questions about this DUA or the use of the CMS data, you may contact me at (410) 786-7185. If you have questions regarding the Care Coordination Program, please contact Karyn Anderson, Part D Care Coordination program official, at (410) 786-6696.

Sincerely,



Cheryl Sample
Division of Information Security & Privacy Management
Enterprise Architecture and Strategy Group
Office of Information Services
Centers for Medicare & Medicaid Services

Enclosures

Cc:
Karyn Anderson, CMS, FCHCO

Attachment A: Part D WA State Data Use Agreement

Centers for Medicare & Medicaid Services (CMS) Data Use Agreement (DUA) Guidelines

1. Requestor agrees to notify CMS if their project is completed sooner than the expiration date specified in the DUA.
2. Requestor agrees that any data provided by CMS will not be physically moved or electronically transmitted in any way from the site indicated in the DUA without expressed written authorization from CMS. If location needs to be modified, the DUA should be updated to include the new location.
3. Upon completion of the project and/or expiration of the DUA, the data must be destroyed and a statement certifying this action sent to CMS. The Requestor agrees that no data, copies, or parts thereof, shall be retained when the file(s) are destroyed, unless CMS has authorized in writing such retention or said file(s). Further details are explained below:

Destroy data and submit a completed Certificate of Destruction (form may be downloaded at: <http://www.cms.hhs.gov/PrivProtectedData/Downloads/certificationofdestruction.pdf>.) The Requestor should forward this information to:

Director, Division of Information Security & Privacy Management
Enterprise Architecture and Strategy Group
Office of Information Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mailstop: N1-24-08
Baltimore, Maryland 21244-1850

4. If the project is still active and the DUA has expired, a one (1) year extension may be granted. The extension will only be approved if the data will continue to be used for the original project purpose and the expiration date has occurred within the past year; otherwise, a new DUA must be negotiated. The letter requesting an extension should be directed to the name and address in item 3a above.
5. Please visit our new website, Privacy Protected Data Request: Policies and Procedures at: <http://www.cms.hhs.gov/PrivProtectedData/>.

Attachment A: Part D WA State Data Use Agreement

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0734

DATA USE AGREEMENT

DUA # 21628

(AGREEMENT FOR USE OF CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) DATA CONTAINING INDIVIDUAL IDENTIFIERS)

CMS agrees to provide the User with data that reside in a CMS Privacy Act System of Records as identified in this Agreement. In exchange, the User agrees to pay any applicable fees; the User agrees to use the data only for purposes that support the User's study, research or project referenced in this Agreement, which has been determined by CMS to provide assistance to CMS in monitoring, managing and improving the Medicare and Medicaid programs or the services provided to beneficiaries; and the User agrees to ensure the integrity, security, and confidentiality of the data by complying with the terms of this Agreement and applicable law, including the Privacy Act and the Health Insurance Portability and Accountability Act. In order to secure data that reside in a CMS Privacy Act System of Records; in order to ensure the integrity, security, and confidentiality of information maintained by the CMS; and to permit appropriate disclosure and use of such data as permitted by law, CMS and Health Care Authority, Washington State enter into this agreement to comply with the following specific paragraphs. (Requestor)

1. This Agreement is by and between the Centers for Medicare & Medicaid Services (CMS), a component of the U.S. Department of Health and Human Services (HHS), and Health Care Authority, Washington State hereinafter termed "User." (Requestor)
2. This Agreement addresses the conditions under which CMS will disclose and the User will obtain, use, reuse and disclose the CMS data file(s) specified in section 5 and/or any derivative file(s) that contain direct individual identifiers or elements that can be used in concert with other information to identify individuals. This Agreement supersedes any and all agreements between the parties with respect to the use of data from the files specified in section 5 and preempts and overrides any instructions, directions, agreements, or other understanding in or pertaining to any grant award or other prior communication from the Department of Health and Human Services or any of its components with respect to the data specified herein. Further, the terms of this Agreement can be changed only by a written modification to this Agreement or by the parties adopting a new agreement. The parties agree further that instructions or interpretations issued to the User concerning this Agreement or the data specified herein, shall not be valid unless issued in writing by the CMS point-of-contact or the CMS signatory to this Agreement shown in section 20.
3. The parties mutually agree that CMS retains all ownership rights to the data file(s) referred to in this Agreement, and that the User does not obtain any right, title, or interest in any of the data furnished by CMS.
4. The User represents, and in furnishing the data file(s) specified in section 5 CMS relies upon such representation, that such data file(s) will be used solely for the following purpose(s).

Name of Study/Project
Care Coordination

CMS Contract No. (if applicable)

CMS Agreement No 2011-13

The User represents further that the facts and statements made in any study or research protocol or project plan submitted to CMS for each purpose are complete and accurate. Further, the User represents that said study protocol(s) or project plans, that have been approved by CMS or other appropriate entity as CMS may determine, represent the total use(s) to which the data file(s) specified in section 5 will be put.

The User agrees not to disclose, use or reuse the data covered by this agreement except as specified in an Attachment to this Agreement or except as CMS shall authorize in writing or as otherwise required by law, sell, rent, lease, loan, or otherwise grant access to the data covered by this Agreement. The User affirms that the requested data is the minimum necessary to achieve the purposes stated in this section. The User agrees that, within the User organization and the organizations of its agents, access to the data covered by this Agreement shall be limited to the minimum amount of data and minimum number of individuals necessary to achieve the purpose stated in this section (i.e., individual's access to the data will be on a need-to-know basis).

Form CMS-R-0235 (06/10)

2

Attachment A: Part D WA State Data Use Agreement

5. The following CMS data file(s) is/are covered under this Agreement.

File	Years(s)	System of Record
Part D Files	2006	System No. 09-70-0571
Part D Files	2007	System No. 09-70-0571
Part D Files	2008	System No. 09-70-0571
Part D Files	2009	System No. 09-70-0571
Part D Files	2010	System No. 09-70-0571
Part D Files	2011	System No. 09-70-0571

6. The parties mutually agree that the aforesaid file(s) (and/or any derivative file(s)), including those files that directly identify individuals or that directly identify bidding firms and/or such firms' proprietary, confidential or specific bidding information, and those files that can be used in concert with other information to identify individuals, may be retained by the User until 07/31/2016, hereinafter known as the "Retention Date." The User agrees to notify CMS within 30 days of the completion of the purpose specified in section 4 if the purpose is completed before the aforementioned retention date. Upon such notice or retention date, whichever occurs sooner, the User agrees to destroy such data. The User agrees to destroy and send written certification of the destruction of the files to CMS within 30 days. The User agrees not to retain CMS files or any parts thereof, after the aforementioned file(s) are destroyed unless the appropriate Systems Manager or the person designated in section 20 of this Agreement grants written authorization. The User acknowledges that the date is not contingent upon action by CMS.

The Agreement may be terminated by either party at any time for any reason upon 30 days written notice. Upon notice of termination by User, CMS will cease releasing data from the file(s) to the User under this Agreement and will notify the User to destroy such data file(s). Sections 3, 4, 6, 8, 9, 10, 11, 13, 14 and 15 shall survive termination of this Agreement.

7. The User agrees to establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized use or access to it. The safeguards shall provide a level and scope of security that is not less than the level and scope of security requirements established by the Office of Management and Budget (OMB) in OMB Circular No. A-130, Appendix III—Security of Federal Automated Information Systems (<http://www.whitehouse.gov/omb/circulars/a130/a130.html>) as well as Federal Information Processing Standard 200 entitled "Minimum Security Requirements for Federal Information and Information Systems" (<http://csrc.nist.gov/publications/fips/fips200/FIPS-200-final-march.pdf>); and, Special Publication 800-53 "Recommended Security Controls for Federal Information Systems" (<http://csrc.nist.gov/publications/nistpubs/800-53-Rev2/sp800-53-rev2-final.pdf>). The User acknowledges that the use of unsecured telecommunications, including the Internet, to transmit individually identifiable, bidder identifiable or deducible information derived from the file(s) specified in section 5 is prohibited. Further, the User agrees that the data must not be physically moved, transmitted or disclosed in any way from or by the site indicated in section 17 without written approval from CMS unless such movement, transmission or disclosure is required by a law.
8. The User agrees to grant access to the data to the authorized representatives of CMS or DHHS Office of the Inspector General at the site indicated in section 17 for the purpose of inspecting to confirm compliance with the terms of this agreement.

Attachment A: Part D WA State Data Use Agreement

9. The User agrees not to disclose direct findings, listings, or information derived from the file(s) specified in section 5, with or without direct identifiers, if such findings, listings, or information can, by themselves or in combination with other data, be used to deduce an individual's identity. Examples of such data elements include, but are not limited to geographic location, age if > 89, sex, diagnosis and procedure, admission/discharge date(s), or date of death.

The User agrees that any use of CMS data in the creation of any document (manuscript, table, chart, study, report, etc.) concerning the purpose specified in section 4 (regardless of whether the report or other writing expressly refers to such purpose, to CMS, or to the files specified in section 5 or any data derived from such files) must adhere to CMS' current cell size suppression policy. This policy stipulates that no cell (e.g. admissions, discharges, patients, services) 10 or less may be displayed. Also, no use of percentages or other mathematical formulas may be used if they result in the display of a cell 10 or less. By signing this Agreement you hereby agree to abide by these rules and, therefore, will not be required to submit any written documents for CMS review. If you are unsure if you meet the above criteria, you may submit your written products for CMS review. CMS agrees to make a determination about approval and to notify the user within 4 to 6 weeks after receipt of findings. CMS may withhold approval for publication only if it determines that the format in which data are presented may result in identification of individual beneficiaries.

10. The User agrees that, absent express written authorization from the appropriate System Manager or the person designated in section 20 of this Agreement to do so, the User shall not attempt to link records included in the file(s) specified in section 5 to any other individually identifiable source of information. This includes attempts to link the data to other CMS data file(s). A protocol that includes the linkage of specific files that has been approved in accordance with section 4 constitutes express authorization from CMS to link files as described in the protocol.
11. The User understands and agrees that they may not reuse original or derivative data file(s) without prior written approval from the appropriate System Manager or the person designated in section 20 of this Agreement.
12. The parties mutually agree that the following specified Attachments are part of this Agreement:

CMS Agreement No 2011-13

13. The User agrees that in the event CMS determines or has a reasonable belief that the User has made or may have made a use, reuse or disclosure of the aforesaid file(s) that is not authorized by this Agreement or another written authorization from the appropriate System Manager or the person designated in section 20 of this Agreement, CMS, at its sole discretion, may require the User to: (a) promptly investigate and report to CMS the User's determinations regarding any alleged or actual unauthorized use, reuse or disclosure; (b) promptly resolve any problems identified by the investigation; (c) if requested by CMS, submit a formal response to an allegation of unauthorized use, reuse or disclosure; (d) if requested by CMS, submit a corrective action plan with steps designed to prevent any future unauthorized uses, reuses or disclosures; and (e) if requested by CMS, return data files to CMS or destroy the data files it received from CMS under this agreement. The User understands that as a result of CMS's determination or reasonable belief that unauthorized uses, reuses or disclosures have taken place, CMS may refuse to release further CMS data to the User for a period of time to be determined by CMS.

The User agrees to report any breach of personally identifiable information (PII) from the CMS data file(s), loss of these data or disclosure to any unauthorized persons to the CMS Action Desk by telephone at (410) 786-2580 or by e-mail notification at cms_it_service_desk@cms.hhs.gov within one hour and to cooperate fully in the federal security incident process. While CMS retains all ownership rights to the data file(s), as outlined above, the User shall bear the cost and liability for any breaches of PII from the data file(s) while they are entrusted to the User. Furthermore, if CMS determines that the risk of harm requires notification of affected individual persons of the security breach and/or other remedies, the User agrees to carry out these remedies without cost to CMS.

Attachment A: Part D WA State Data Use Agreement

14. The User hereby acknowledges that criminal penalties under §1106(a) of the Social Security Act (42 U.S.C. § 1306(a)), including a fine not exceeding \$10,000 or imprisonment not exceeding 5 years, or both, may apply to disclosures of information that are covered by § 1106 and that are not authorized by regulation or by Federal law. The User further acknowledges that criminal penalties under the Privacy Act (5 U.S.C. § 552a(i) (3)) may apply if it is determined that the Requestor or Custodian, or any individual employed or affiliated therewith, knowingly and willfully obtained the file(s) under false pretenses. Any person found to have violated sec. (i)(3) of the Privacy Act shall be guilty of a misdemeanor and fined not more than \$5,000. Finally, the User acknowledges that criminal penalties may be imposed under 18 U.S.C. § 641 if it is determined that the User, or any individual employed or affiliated therewith, has taken or converted to his own use data file(s), or received the file(s) knowing that they were stolen or converted. Under such circumstances, they shall be fined under Title 18 or imprisoned not more than 10 years, or both; but if the value of such property does not exceed the sum of \$1,000, they shall be fined under Title 18 or imprisoned not more than 1 year, or both.
15. By signing this Agreement, the User agrees to abide by all provisions set out in this Agreement and acknowledges having received notice of potential criminal or administrative penalties for violation of the terms of the Agreement.
16. On behalf of the User the undersigned individual hereby attests that he or she is authorized to legally bind the User to the terms this Agreement and agrees to all the terms specified herein.

Name and Title of User (typed or printed)		
Cathie Ott		
Company/Organization		
Health Care Authority		
Street Address		
626 8th Ave		
City	State	ZIP Code
Olympia	WA	98504-5502
Office Telephone (Include Area Code)		E-Mail Address (if applicable)
360-725-2116		ottcl@hca.wa.gov
Signature		Date
Cathie Ott		7/12/2011

17. The parties mutually agree that the following named individual is designated as Custodian of the file(s) on behalf of the User and will be the person responsible for the observance of all conditions of use and for establishment and maintenance of security arrangements as specified in this Agreement to prevent unauthorized use. The User agrees to notify CMS within fifteen (15) days of any change of custodianship. The parties mutually agree that CMS may disapprove the appointment of a custodian or may require the appointment of a new custodian at any time.

The Custodian hereby acknowledges his/her appointment as Custodian of the aforesaid file(s) on behalf of the User, and agrees to comply with all of the provisions of this Agreement on behalf of the User.

Name of Custodian (typed or printed)		
Cathie Ott		
Company/Organization		
Health Care Authority		
Street Address		
626 8th Avenue		
City	State	ZIP Code
Olympia	WA	98504-5502
Office Telephone (Include Area Code)		E-Mail Address (if applicable)
360-725-2116		ottcl@hca.wa.gov
Signature		Date
Cathie Ott		7/12/2011

Attachment A: Part D WA State Data Use Agreement

18. The disclosure provision(s) that allows the discretionary release of CMS data for the purpose(s) stated in section 4 follow(s). (To be completed by CMS staff.) _____

19. On behalf of _____ the undersigned individual hereby acknowledges that the aforesaid Federal agency sponsors or otherwise supports the User's request for and use of CMS data, agrees to support CMS in ensuring that the User maintains and uses CMS's data in accordance with the terms of this Agreement, and agrees further to make no statement to the User concerning the interpretation of the terms of this Agreement and to refer all questions of such interpretation or compliance with the terms of this Agreement to the CMS official named in section 20 (or to his or her successor).

Typed or Printed Name		Title of Federal Representative	
Signature		Date	
Office Telephone (include Area Code)		E-Mail Address (if applicable)	

20. The parties mutually agree that the following named individual will be designated as point-of-contact for the Agreement on behalf of CMS.

On behalf of CMS the undersigned individual hereby attests that he or she is authorized to enter into this Agreement and agrees to all the terms specified herein.

Name of CMS Representative (typed or printed)			
Karyn Kai Anderson			
Title/Component			
Medicare-Medicaid Coordination Office			
Street Address			Mail Stop
7500 Security Blvd.			53-13-23
City	State	ZIP Code	
Baltimore	MD	21244	
Office Telephone (include Area Code)		E-Mail Address (if applicable)	
410-786-6696		Karyn.Anderson@CMS.hhs.gov	
A. Signature of CMS Representative			Date
			7/22/11
B. Concur/Nonconcur — Signature of CMS System Manager or Business Owner			Date
			7/22/11
Concur/Nonconcur — Signature of CMS System Manager or Business Owner			Date
Concur/Nonconcur — Signature of CMS System Manager or Business Owner			Date

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0734. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-0235 (06/10)

6

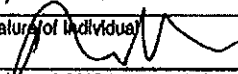
Attachment A: Part D WA State Data Use Agreement

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0734

ADDENDUM TO DATA USE AGREEMENT (DUA)

Addendum to DUA for Care Coordination for Dual Eligibles . If this is an addendum to a previously approved DUA, insert the CMS assigned DUA number here: 21628. The following individual(s) may/will have access to CMS data that is being requested for this agreement. Their signatures attest to their agreement to the terms of this Data Use Agreement:

Name and Title of Individual (typed or printed) David Mancuso, PhD		
Task / Role of this individual in this project Senior Research Supervisor		Company / Organization Department of Social and Health Services
Street Address 14th and Jefferson, OB-2, MS: 45204		
City Olympia	State WA	ZIP Code 98504
Office Telephone (include Area Code) (360) 902-7557		E-Mail Address (if applicable) MancusoDC@dshs.wa.gov
Signature of Individual 		Date 8/2/2011
Signature of CMS Representative		Date
Signature of CMS Project Officer (if applicable)		Date

Name and Title of Individual (typed or printed)		
Task / Role of this individual in this project		Company / Organization
Street Address		
City	State	ZIP Code
Office Telephone (include Area Code)		E-Mail Address (if applicable)
Signature of Individual		Date
Signature of CMS Representative		Date
Signature of CMS Project Officer (if applicable)		Date

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0734. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-0235A (03/06) EF 03/2008

Attachment A: Part D WA State Data Use Agreement

Data Agreement & Data Shipping Tracking System

Page 1 of 3

The Centers for Medicare and Medicaid Services Data Agreement & Data Shipping Tracking System

DADSS
Home

| Manage DUAs | Manage Orders | Data Files | Contacts | Reports | Misc Functions | Help |

DUA

DUA Search

Search Results

Archived DUAs

Unfinished
DUAs

DUA Entry

Login Status

CHERYL
SAMPLE

5:22 PM

Logout

DUA Search

Search Results

Archived DUAs

Unfinished
DUAs

DUA Entry

dua edit - dua: 21628

1-Main Information 2-Data Descriptions 3-IDR Custodians 4-Requestor
5-Custodians 6-Subcontractors 7-Recipients 8-DESY Users 9-Comments
10-Finish

Session Summary:

DUA: 21628

Main Information:

DUA #: 21628
Study Name: CARE COORDINATION FOR BENEFICIARIES WHO ARE
DUALY ELIGIBLE IN THE MEDICARE/MEDICAID
PROGRAMS
Category: 11 - STATES
Encryption: I - IDENTIFIABLE
Authorization: PA03-ST - STATE AGENCY RU
Privacy Board Approval Date:
DUA Effective Date: 08/02/2011 DUA Expiration Date: 07/13/2016
Extension: 0 Extension Date:
DESY Access: No DESY Expiration Date:
Reuse: No Reuse Information: NUL
DSAF Access: No CMS Data Center Access: No
Foreign Tape: No
Bene Notification: N - NOT APPLICABLE
Contract/Grant No.: CMS/STATE IEA AGREEMENT #2011-13
Part D Approval Date: 07/22/2011
CMS Contact Name: KARYN ANDERSON
Federal Project Officer:

Data Descriptions:

#1 Data Description: PDE - PRESCRIPTION DRUG EVENT DATA
From Year: 2007 To Year: 2011

IDR Custodians:

Requestor:

Address ID: 20120 Contact Info: CATHIE OTT
STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8TH AVENUE SE
OLYMPIA, WA 98504
UNITED STATES OF AMERICA
Phone: 360-725-2116
Email: ottcl@hca.wa.gov
Last Modified: 2011-08-02 14:47:24

Custodians:

#1 Address ID: 20120 Contact Info: CATHIE OTT
STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8TH AVENUE SE
OLYMPIA, WA 98504
UNITED STATES OF AMERICA
Phone: 360-725-2116
Email: ottcl@hca.wa.gov
Last Modified: 2011-08-02 14:47:24

#2 Address ID: 18110 Contact Info: DAVID MANCUSO
WASHINGTON DEPARTMENT OF SOCIAL AND
HEALTH SERVICES

<https://dadss.cmsnet/dadss/dua/duafin.do>

08/04/2011

Attachment A: Part D WA State Data Use Agreement

Data Agreement & Data Shipping Tracking System

Page 2 of 3

AGING AND DISABILITY SERVICES
ADMINISTRATION
14TH & JEFFERSON STREET
PO BOX 45204
OLYMPIA, WA 98504
UNITED STATES OF AMERICA
Phone: 360-902-7557
Email: mancudc@dshs.wa.gov
Last Modified: 2011-08-04 16:01:09

Subcontractors:

None

Recipients:

#1 Address ID: 20120

Contact Info: CATHIE OTT

STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8TH AVENUE SE
OLYMPIA, WA 98504
UNITED STATES OF AMERICA
Phone: 360-725-2116
Email: ottcl@hca.wa.gov
Last Modified: 2011-08-02 14:47:24

#2 Address ID: 18110

Contact Info: DAVID MANCUSO

WASHINGTON DEPARTMENT OF SOCIAL AND
HEALTH SERVICES
AGING AND DISABILITY SERVICES
ADMINISTRATION
14TH & JEFFERSON STREET
PO BOX 45204
OLYMPIA, WA 98504
UNITED STATES OF AMERICA
Phone: 360-902-7557
Email: mancudc@dshs.wa.gov
Last Modified: 2011-08-04 16:01:09

DESY Users:

Comments:

Timestamp: Thu Aug 04 17:24:26 EDT 2011

User Name: CHERYL SAMPLE

Text: added David Mancuso as additional data custodian.

Timestamp: Tue Aug 02 14:51:36 EDT 2011

User Name: CHERYL SAMPLE

Text: WA approved by PDE business owner for use of PDE data (IEA lists data elements--27) for care coordination program under direction of Sharon Donovan and Kai Anderson, CMS/ FCHCO/Duals Office program officials. OIS/EDG to process data feed.

History:

Timestamp: Thu Aug 04 17:24:21 EDT 2011

User Name: CHERYL SAMPLE

Type of Change: RECIPIENT HAS BEEN ADDED

Timestamp: Thu Aug 04 17:24:21 EDT 2011

User Name: CHERYL SAMPLE

Type of Change: CUSTODIAN HAS BEEN ADDED

<https://dadss.cmsnet/dadss/dua/duafin.do>

08/04/2011

Attachment B: Supplement to Data Use Agreement

This Attachment supplements the Data Use Agreement between the Centers for Medicare & Medicaid Services ("CMS") and the Users. To the extent that the provisions of this Attachment are inconsistent with any terms in the Data Use Agreement, this Attachment modifies and overrides the Data Use Agreement.

USE OF THE INFORMATION

A-1. Users are defined as the State Medicaid Agencies and downstream entities that are Health Insurance Portability and Accountability Act (HIPAA) Covered Entities that are given individually identifiable data to carry out care coordination and quality improvement work, as well as the business associates of such entities and any sub-contractor Business Associates of such entities.

Users may include providers and care coordination organizations that wish to use individually identifiable data about beneficiaries of the Medicare and Medicaid programs (Medicare-Medicaid enrollees) to provide care coordination and quality improvement programs on behalf of the State Medicaid Agency and/or one or more HIPAA Covered Entity providers. Such work would need to be done subject to a HIPAA business associate agreement with that State Medicaid Agency and/or those HIPAA Covered Entity providers.

The Users must use any individually identifiable information that they receive under A-1 to further the delivery of seamless, coordinated care for individuals who are Medicare-Medicaid enrollees to promote better care, better health, and lower growth in expenditures.

A-2. Subject to the limitations described below, users may reuse original or derivative data from the files specified in Section 5 of the Data Use Agreement, with or without direct identifiers, without prior written authorization from CMS, for clinical treatment, case management and care coordination, and quality improvement activities. Information derived from the files specified in Section 5 of the Data Use Agreement may be shared and used within the legal confines of the Users authority in a manner consistent with this section to improve care integration. When using or disclosing protected health information (PHI) or personally identifiable information (PII), obtained under the Data Use Agreement, Users must make "reasonable efforts to limit" the information that is used or disclosed to the "minimum necessary" to accomplish the intended purpose of the use or disclosure. Users shall limit disclosure of information to that which CMS would be permitted to disclose under the established Privacy Act "routine uses," which are categories of disclosures or uses permitted by CMS's system of records notice available at www.cms.hhs.gov/privacy, as well as other permitted disclosures found in the Privacy Act at 5 U.S.C. § 552a(b)(1) through (b)(12).

Attachment B: Supplement to Data Use Agreement


A-3. Nothing in the Data Use Agreement, including but not limited to Section 9, governs the use and/or disclosure of any information that is obtained independent of the Data Use Agreement, regardless of whether the information was also obtained or could also be derived from the files specified in Section 5 of the Data Use Agreement.

A-4. Users are expressly authorized to undertake further investigation into events and individuals related to the files specified in Section 5 in a manner consistent with Section A-2. This includes, but is not limited to, reviewing other records, interviewing individuals, and attempting to link the files specified in Section 5 to other files.

POTENTIAL PENALTIES

A-5. Users acknowledge having received notice of potential criminal or administrative penalties for violation of the terms of the Data Use Agreement and this attachment.

Washington State Health Care Authority
For: State Medicaid Agency

 LESLIE J. DAVIS, CFO
For: Provider, Care Coordination Organization, or Administrative Contractor
UNITED BEHAVIORAL HEALTH

Attachment C: Part D Conflict of Interest

[Health Home Lead Entity letterhead]

[Date]

Beverly Court
Department of Social and Health Services
Research and Data Analysis Division
1114 Washington Street SE
PO Box 45204
Olympia, WA 98504-5204

Dear Beverly Court,

As a contractor of Washington's Medicaid agency, [Lead Entity Name] intends to receive Centers for Medicare & Medicaid Services (CMS) data from Washington State for coordination of care, quality improvement and/or treatment of persons enrolled in both Medicare and Medicaid. We will also be subcontracting with entities who will also access CMS data for care coordination, quality improvement and/or treatment purposes.

We understand that CMS wants assurance that potential conflict of interest related to also operating or affiliation with Part D plans is mitigated when necessary through separation and security of CMS data used for clinical treatment, case management and care coordination, and quality improvement activities.

The contact person for conflict of interest matters within our organization is [Contact's First and Last Name] who can be reached by email at [email address] or by phone at [phone number].

The following organizations are covered in this attestation that no conflict of interest exists:

[Name of Contractor/Subcontractor with no conflict of interest]

[Name of Subcontractor with no conflict of interest]

The following organizations are covered in this attestation that conflict of interest potentially does exist, and steps to mitigate said conflict of interest, including separation and security of any CMS data acquired through its work with Washington State to isolate CMS data from unrelated activities in their organization, have been taken:

[Name of Contractor/Subcontractor with potential conflict of interest]

[Name of Subcontractor with potential conflict of interest]

Sincerely,

[Signature of person who can legally bind your Organization to the statements above, such as legal staff or organization officer]

[Title]



**DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Privacy Act of 1974**

**INFORMATION EXCHANGE AGREEMENT
BETWEEN
CENTERS FOR MEDICARE & MEDICAID SERVICES
AND
THE PARTICIPATING STATE MEDICAID AGENCY
FOR
DISCLOSURE OF MEDICARE PART D DATA
CMS Computer Matching Agreement Number 2011-13
WASHINGTON STATE**

INFORMATION EXCHANGE AGREEMENT

**INFORMATION EXCHANGE AGREEMENT
BETWEEN
CENTERS FOR MEDICARE & MEDICAID SERVICES
AND
THE PARTICIPATING STATE MEDICAID AGENCY
FOR
DISCLOSURE OF MEDICARE PART D DATA**

CMS AGREEMENT No. 2011-13

I. PURPOSE, LEGAL AUTHORITY, AND DEFINITIONS

A. Purpose

This Information Exchange Agreement (IEA) establishes the terms, conditions, safeguards, and procedures under which the Centers for Medicare & Medicaid Services (CMS) will disclose Medicare Part D prescription drug event (PDE) data to the State Medicaid Agency for the State of Washington ("the Participating State"). Under this Agreement, PDE data that are maintained by CMS and subject to the requirements of the Privacy Act will be disclosed exclusively for use in care coordination for beneficiaries who are dually eligible for both the Medicare and Medicaid programs ("dual eligible beneficiaries"). The criteria for considering a purpose to be "care coordination" is that the specific uses of the data (e.g., analysis, monitoring, or feedback) support interventions at the individual dual eligible beneficiary level that have the potential to improve the care of dual eligible beneficiaries.

This Agreement describes the Medicare Part D PDE data elements that CMS agrees to provide, the timeframes within which the data or access will be provided, the approved uses of the data, the approved downstream disclosures of the data (if applicable), and the CMS reporting requirements. Certain protections for the data that are required under the terms of this IEA are reinforced in the Data Use Agreement (DUA) Form CMS-R-0235.

B. Legal Authority

The legal authority for CMS's disclosure of information to the State Medicaid agency is provided by the Privacy Act of 1974 (5 U.S.C. § 552a), as amended, section 1106(a) of the Social Security Act (42 U.S.C. § 1306(a)), and the regulations and guidance promulgated thereunder. The release of Part D data by CMS to a State is also governed by 42 CFR 423.505. CMS data will be released to the State Medicaid Agency pursuant to the routine use as set forth in the system notice.

Disclosures under this agreement do not constitute a matching program as defined by the Privacy Act, 5 U.S.C. § 552a (a)(8), but are made in accordance with applicable requirements and other relevant provisions of the Privacy Act, 5 U.S.C. § 552a. The purpose of the disclosures described herein is not for (1) establishing or verifying initial

or continuing entitlement or eligibility of individuals or entities (be they applicants for, recipients of, participants in, or providers of services) with respect to Federal benefit programs, (2) verifying compliance with statutory and regulatory requirements of such programs, or (3) recouping payments or delinquent debts under such Federal benefit programs.

This Agreement supports the responsibilities of the Federal Coordinated Health Care Office ("Medicare-Medicaid Coordination Office") as established by the Patient Protection and Affordable Care Act (Affordable Care Act) Section 2602, which specifically include providing States with the tools necessary to develop programs to align Medicare and Medicaid benefits for dual eligible beneficiaries.

C. Definitions

1. "BI" means Business Intelligence (BI) tool.
2. "Care coordination" means uses of the data (e.g., analysis, monitoring, or feedback) to support interventions at the individual dual eligible beneficiary level that have the potential to improve the care of dual eligible beneficiaries.
3. "CMS" means the Centers for Medicare & Medicaid Services.
4. "Custodian" or "custodian agent" means a designated employee of the State Medicaid Agency who is responsible for protecting the confidentiality of data disclosed in accordance with this agreement.
5. "Downstream user" means any entity (e.g., treating provider or contractor) that has been approved by CMS to receive PDB data that was provided to the State Medicaid Agency under this Agreement for care coordination purposes.
6. "DUA" means the CMS Data Use Agreement which accompanies this IBA.
7. "Dual eligible beneficiary" means an individual who is concomitantly enrolled in Medicare and has been determined to be eligible for full benefits under the Participating State's Medicaid program.
8. "Medicare-Medicaid Coordination Office" or "MMCO" means the Federal Coordinated Health Care Office.
9. "HIPAA" means the Health Insurance Portability and Accountability Act.
10. "Medicaid" means the Medicaid program established under Title XIX of the Social Security Act.
11. "Medicare" means the health insurance program established under Title XVIII of the Social Security Act.

12. "PDE data" means Medicare Part D Prescription Drug Event data that are reported to CMS by Part D prescription drug plan sponsors and maintained by CMS.

13. "State Medicaid Agency" means the Medicaid Agency for the State of Washington.

14. "Treating provider" is a clinician who is currently responsible for care provision and/or care coordination for dual eligible beneficiaries.

II. RESPONSIBILITIES OF CMS AND STATE MEDICAID AGENCY

Under the terms of this Agreement, CMS will provide to the State Medicaid agency certain Medicare PDE data maintained by CMS. PDE data will only be shared for dual eligible beneficiaries who are eligible to receive full Medicaid benefits in the Participating State; PDE data for this population will be made available to the Participating State whether or not the prescription was filled in the Participating State. Financial data and internal plan and pharmacy prescription identification numbers will be excluded as indicated in MMCO-CMCS Informational Bulletin of May 11, 2011.

CMS will provide to the State Medicaid Agency the tools necessary to develop, implement, and monitor care coordination programs to better align and improve the delivery of Medicare and Medicaid benefits for dual eligible beneficiaries. In accordance with the stipulations described throughout both this Agreement and the DUA, this data sharing Agreement will permit State Medicaid Agencies to use and disclose Medicare Part D data solely for CMS-approved purposes.

Once CMS approves the State Medicaid Agency's PDE data requests, the State or its custodian should fill out the attached "Approved Uses and Downstream Users." (Please see Attachment 1). CMS will provide the State with access to Medicare Part D PDE data that may include a one-time file of historical data as well as subsequent PDE data updated on a monthly basis. The State Medicaid Agency or its custodian represents further that the facts and statements made in any data use proposal submitted to CMS using Attachment 1 are complete and accurate. Further, the State Medicaid Agency or its custodian represents that said data uses listed in Attachment 1, and as approved by CMS, represent the total use(s) to which the PDE data will be applied.

The PDE data disclosed under this IBA will be used by State Medicaid Agency employees and approved downstream users solely for the uses and purposes identified above. All downstream users that will receive, view or access these data must hold a valid and current state data use agreement with the State Medicaid Agency. The state data use agreement must comply with all the terms and conditions of this IBA and the applicable CMS DUA. The State Medicaid Agency must obtain prior CMS approval in the form of an additional DUA Addendum before sharing these data with any additional downstream user. These data may not be used for any purposes that are not indicated in this agreement, such as research, fraud detection, or payment (e.g., calculating risk adjustment factors).

In exchange for the data provided under this Agreement, every six months the State Medicaid Agency agrees to brief CMS on whether and how the data are being used and the results of its care coordination activities. Among these results will be findings on potential best practices for care coordination, quality improvement, and cost savings. In addition, the State Medicaid Agency will provide directly to CMS any written reports based on these results, which may be used or disseminated by CMS at its discretion. Upon request by CMS at any time, the State Medicaid Agency will also provide CMS with any additional updates as requested. Finally, if requested by CMS, and if the CMS use of the data complies with the Privacy Act and is otherwise permitted by law, the State Medicaid Agency will provide to CMS all linked Medicare/Medicaid data that have been made possible by this data sharing Agreement.

III. DESCRIPTION OF THE DATA TO BE DISCLOSED

Each Information Exchange Agreement for protected data must describe the records which will be matched and exchanged, including a sample of data elements that will be used, the approximate number of records that will be matched, and the projected starting and completion dates of the program.

A. Systems of Records

CMS data that will be released to the State Medicaid Agency are maintained in the following database: Medicare Integrated Data Repository (IDR), System No. 09-70-0571 was published at 71 Fed. Reg. 74915 (December 13, 2006). Data maintained in this system will be released pursuant to routine use number 2 as set forth in the system notice. (A copy of the system notice is given as Attachment 2).

B. Projected Starting and Completion Dates

The Agreement shall remain in effect for a period not to exceed 5 years; however, within 3 months prior to the expiration of this Agreement, without additional review, CMS may renew this Agreement for not more than 5 additional years.

C. Number of Records Involved and Operational Time Factors

1. CMS PDB records in 2010 contained approximately 336 million individual Medicare PDE records for dual eligible beneficiaries. Medicare records disclosed to the Participating State under this agreement will include approved PDE data elements for approved timeframes for all dual eligible beneficiaries residing in the Participating State.
2. The total full benefit dual eligible beneficiary population of all States in 2010 includes approximately 7 million individuals. Each Participating State's records file will contain records representing that State's approved PDB data elements for approved time frames for its full benefit dual eligible beneficiaries.

IV. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

The State Medicaid Agency will only use the data disclosed under this agreement for the care coordination activities described herein, and will assure that any downstream users with whom it is approved to share these data limit their use to care coordination activities as approved by CMS. In the event these care coordination activities terminate, the State Medicaid Agency will be required to return to CMS or destroy the data files and any derivative data files.

V. PROCEDURES FOR SECURITY

A. CMS and the State Medicaid Agency agree to safeguard the Medicare PDE data as follows:

1. CMS and the State Medicaid Agency will comply with all Federal laws, guidance, and policies for all automated information systems security. For computerized records, safeguards have been established in accordance with the Privacy Act of 1974, as amended, the Computer Security Act of 1987, OMB Circular A-130, revised, Information Resource Management Circular No. 10, HHS Automated Information Systems Security Program, CMS's "IT Systems Security Policies, Standards, and Guidelines Handbook," and other CMS systems security policies. In accordance with the Privacy Act, each automated information system must ensure a level of security commensurate with the level of sensitivity of the data, risk, and magnitude of the harm that may result from the loss, misuse, disclosure, or modification of the information contained in the system.
2. CMS and the State Medicaid Agency will limit access to the data and any derivative files to authorized employees and officials who need them to perform their official duties in connection with the uses and disclosures authorized under this Agreement. Further, all personnel who will have access to the data and any derivative files will be advised of the confidential nature of the information, the safeguards required to protect the records, and the civil and criminal sanctions for non-compliance contained in applicable Federal laws.
3. The State Medicaid Agency will only disclose the data and any derivative files with downstream users after it receives explicit prior approval from CMS. If a disclosure is approved, State Medicaid Agency will place limitations on the downstream user's reuse or redisclosure of the data as a condition of the release of the data. Such limitations are to include a provision barring reuse or redisclosure absent CMS written prior approval.
4. The State Medicaid Agency agrees to limit approved data users to employees of the State Medicaid Agency or users who have a signed data use agreement with the State Medicaid Agency. If data provided under this Agreement are to be shared with a contractor or any other downstream users, the state data use agreement with those users must include all of the data security provisions within this Agreement, and the

attachments or exhibits to this Agreement. If any contractor or any other downstream user cannot protect the data as articulated within this Agreement and the attachments or exhibits to this Agreement, then the CMS contact must be notified in writing, data-sharing with that user must be terminated immediately, and data must be destroyed or returned to the State Medicaid Agency. Access to the Medicare PDE data protected by this Agreement will be controlled by the State Medicaid Agency staff who will issue authentication credentials (e.g., a unique user ID and complex password) to authorized downstream users. Contractor or other downstream users will notify State Medicaid Agency staff immediately whenever an authorized person in possession of such credentials is terminated or otherwise leaves the employ of the contractor or other downstream user, and whenever a user's duties change such that the user no longer requires access to perform work for this Agreement.

5. The records provided and any records created by the project will be stored in an area that is physically safe from access by unauthorized persons during duty hours as well as non-duty hours or when not in use.
 6. The records provided, and any records created by the match, will be processed under the immediate supervision and control of authorized personnel, to protect the confidentiality of the records in such a way that unauthorized persons cannot retrieve any such records by means of computer, remote terminal, or other means.
 7. The records provided and records created by the project will be transported under appropriate safeguards in compliance with Section 7 of the DUA. This includes encrypting any data that will be in transit outside the State Medicaid Agency's internal network, for example, during transit over the public Internet.
 8. CMS may make onsite inspections, with or without advance notice, and may make other provisions to ensure that the State Medicaid Agency and any downstream users are maintaining adequate safeguards.
- B. The Participating State agency shall report any breach, inappropriate use of data, or security incident of which it becomes aware CMS within one hour. CMS will take actions in response to any data breach, inappropriate use of data, or security incident in accordance with CMS Breach Notification Procedures, as defined in Memorandum ISP-2007-007 entitled, "Departmental Response to the Office of Management and Budget (OMB) Memorandum (M) 07-16," Safeguarding Against and Responding to the Breach of Personally Identifiable Information, and the HIPAA Security Rule.

VI. RECORDS USAGE, DUPLICATION AND REDISCLOSURE RESTRICTIONS

The State Medicaid Agency agrees to the following limitations on the access to, and disclosure and use of, the electronic files and information provided by CMS:

- A. That the files provided by CMS as part of this Agreement will remain the property of CMS and will be returned or destroyed as soon as the use, as stipulated by Section I.A of

this Agreement, of the data by the State Medicaid Agency is completed.

- B. That the data supplied by CMS will be used only as provided in this Agreement.
- C. That the files provided by CMS will not be used to extract information concerning the individuals therein for any purpose not specified in this Agreement.
- D. That the files provided by CMS will only be duplicated, disseminated, and accessed within the State Medicaid Agency or with CMS-approved downstream users per the conditions stipulated in this Agreement. The PDE data provided by CMS will only be disclosed outside the State Medicaid Agency if there is signed DUA with each downstream user, and CMS has approved the disclosure per Section II of this Agreement. Otherwise, CMS shall not give such permission unless the redisclosure is required by law.
- E. That the files will not be used to investigate fraud and that the files will not be matched to any files that are used for purposes of fraud detection.

VII. REIMBURSEMENT AND REPORTING

No funds will be exchanged under this Information Exchange Agreement for any work to be performed by the Participating State to carry out the requirements of this IEA. CMS will provide data to the State Medicaid Agency at no cost.

VIII. APPROVAL AND DURATION OF AGREEMENT

- A. This Agreement is effective upon approval by CMS and the State Medicaid Agency signatories and remains in effect indefinitely or until it is amended or superseded by a new Agreement. This Agreement may be amended at any time through a written modification that is signed by both parties.
- B. Either party may unilaterally terminate this Agreement upon written notice to the other party, in which case the termination shall generally be effective 30 days after the date of the notice or at a later date specified in the notice, but in no instance shall such a termination be effective prior to the return or destruction of all data that were supplied to the State Medicaid Agency and to downstream entities in accordance with Section IV of this Agreement.
- C. CMS may immediately and unilaterally terminate this Agreement if CMS determines that there have been unauthorized uses or redisclosures of the data by the State Medicaid Agency or downstream users, a violation of the security requirements of the data, or a violation of, or a failure to follow, any of the terms of this Agreement. In such cases, termination shall be effective in 24 hours from the time and date of such determination; any and all data that were supplied to the State Medicaid Agency are to be destroyed or returned to CMS within 24 hours of the determination, per Section IV of this agreement, and; the State Medicaid Agency will be subject to any or all applicable penalties in accordance with applicable law.

- D. CMS may make a unilateral suspension of this Agreement if it suspects that the State Medicaid Agency has breached the terms for privacy and security of data until such time as CMS makes a definite determination regarding a breach.
- E. CMS may unilaterally terminate this Agreement if there is no evidence that the State Medicaid Agency has used the data for care coordination purposes within nine (9) months of receiving it.

IX. PERSONS TO CONTACT

- A. The CMS program and policy contact:

Karyn Kai Anderson, Ph.D., M.P.H.
Federal Coordinated Health Care Office
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop: S3-13-23
Baltimore, MD 21244-1850
(410) 786-6696
E-Mail: Karyn.Anderson@cms.hhs.gov


- B. The CMS contact for Privacy issues:

Walter Stone
CMS Privacy Officer
Division of Privacy Compliance
Enterprise Architecture & Strategy Group
Office of Information Services
Mail-stop N1-24-08
7500 Security Boulevard
Baltimore Md. 21244-1850
Phone: (410) 786-5357
Fax: (410) 786-5636
Walter.Stone@cms.gov

- C. The contact person for the State Medicaid Agency can be found on the State's signature page.
- D. The contact person for the Custodian can be found on the Custodian signature page.

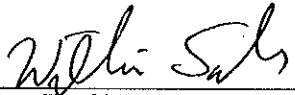
X. APPROVALS**A. Centers for Medicare & Medicaid Services Program Official**

The authorized program official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirms that no verbal agreements of any kind shall be binding or recognized, and hereby commits their respective organization to the terms of this Agreement.

Approved by (Signature of Authorized CMS Program Official)	
	
Sharon Donovan Group Director Program Alignment Group Federal Coordinated Health Care Office Centers for Medicare & Medicaid Services	Date: 8/9/11

B. Centers for Medicare & Medicaid Services Approving Official

The authorized approving official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirms that no verbal agreements of any kind shall be binding or recognized, and hereby commits their respective organization to the terms of this Agreement.

Approved By (Signature of Authorized CMS Approving Official)	
	
G Tony Trenkle Chief Information Officer & Director Office of Information Services Centers for Medicare & Medicaid Services	Date: 8/24/2011

Attachment D: WA State Information Exchange Agreement

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C. Participating State Program Official

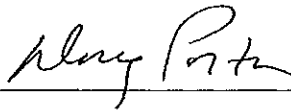
The authorized Participating State program official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirm that no verbal agreements of any kind shall be binding or recognized, and hereby commits their respective organization to the terms of this Agreement.

NAME OF PARTICIPATING STATE MEDICAID AGENCY

State of Washington

Health Care Authority

Approved By (Signature of Authorized State Approving Official)



Doug Porter
Director
Health Care Authority

Date:

7-28-11

PERSONS TO CONTACT

The Health Care Authority for Approval Issues:

Doug Porter
Director
Health Care Authority
Post Office Box 45502
626 8th Avenue, SE
Olympia, WA 98504-5502
Office: (360) 725-1863
Facsimile: (360) 586-9551
E-Mail: PORTBJD@hca.wa.gov

D. State Agency Custodian Official

The authorized State Agency Custodial official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirm that no verbal agreements of any kind shall be binding or recognized, and hereby commits their respective organization to the terms of this Agreement.

NAME OF PARTICIPATING STATE MEDICAID AGENCY

State of Washington

Health Care Authority

Approved By (Signature of Authorized State Custodian Official)



Cathie Ott
Deputy Chief Information Officer
Health Care Authority

Date:

8/1/2011

PERSONS TO CONTACT

The Health Care Authority for Data Custodian issues contact:

Cathie Ott
Deputy Chief Information Officer
Health Care Authority
Post Office Box 45564
626 8th Avenue, SE
Olympia, WA 98504-5564
Office: (360) 725-2116
Facsimile: (360) 586-9551
E-Mail: OTTCL@hca.wa.gov

Attachments:

- 1) Approved Uses and Downstream Users
- 2) System Notice -- CMS No. 09-70-0571--Medicare Integrated Data Repository

Attachment 1 –Approved Uses and Downstream Users

States should fill out the first four columns of the following table. Additional rows may be added as necessary. The last column is to be completed by CMS as confirmation that the requested disclosures, including planned use, purpose, data user, and downstream entity, have been prior-approved by CMS as acceptable.

Planned Use or disclosure of PDE Data	Purpose (i.e., how the Planned Use supports goals of care coordination)	Data User category (State Medicaid Agency staff and/or other Downstream User)	Name of Downstream User (if applicable)	Approved ? (for CMS use only)
Development of predictive risk indicators - ie risk of future hospital admission, nursing home placement, future medical expenditures, etc.	Analysis of high opportunity conditions and individuals for targeting of specific care coordination / support strategies	State Medicaid Agency staff and other downstream users	CMS; Other state agencies; Sub-contracted analysts	
Development of web-based clinical decision support tool, PRISM (Predictive Risk Intelligence System) integrating risk factors and available data for care coordinators and management of health care and related services	To enable care coordinators to easily view integrated patient data and effectively implement care coordination	State Medicaid Agency staff and other downstream users	CMS; Other state agencies; Sub-contracted care coordination organizations / individuals	
Patient summaries provided by care coordinators to patients, families and treating health providers, such as medication lists; health risk summaries	To implement care coordination, care plans and treatment alternatives	State Medicaid Agency staff and other downstream users	CMS; Other state agencies; Sub-contracted care coordination organizations/individuals; Patients, Families, Treating health providers	

Attachment D: WA State Information Exchange Agreement

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Planned Use or disclosure of PDE Data	Purpose (i.e., how the Planned Use supports goals of care coordination)	Data User category (State Medicaid Agency staff and/or other Downstream User)	Name of Downstream User (if applicable)	Approved ? (for CMS use only)
Program Administration - Model development and analysis including quality and performance incentive alternatives; sub-population profiles (utilization, costs, outcomes, access); development of performance measures, clinical guidelines, performance feedback reports; program monitoring and evaluation including client and provider surveys	For care coordination program and model development, implementation, analysis, monitoring and feedback Analysis and monitoring through profiling of utilization, costs, outcomes and access of the dual population for care coordination program development and modeling of program, quality and performance incentive alternatives	State Medicaid Agency staff and other downstream users	CMS; Other state agencies; Sub-contracted analysts / evaluators	

Attachment 2 -- System Notice

CMS No. 09-70-0571--Medicare Integrated Data Repository

SYSTEM NO. 09-70-0571

SYSTEM NAME:

"Medicare Integrated Data Repository (IDR), HHS/CMS/OIS"

SECURITY CLASSIFICATION:

Level Three Privacy Act Sensitive Data

SYSTEM LOCATION:

The Centers for Medicare & Medicaid Services (CMS) Data Center, 7500 Security Boulevard, North Building, First Floor, Baltimore, Maryland 21244-1850.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

This system maintains information on individuals age 65 or over who have been, or currently are, entitled to health insurance (Medicare) benefits under Title XVIII of the Social Security Act (the Act) or under provisions of the Railroad Retirement Act; individuals under age 65 who have been, or currently are, entitled to such benefits on the basis of having been entitled for not less than 24 months to disability benefits under Title II of the Act or under the Railroad Retirement Act; individuals who have been, or currently are, entitled to such benefits because they have End-Stage Renal Disease (ESRD); individuals age 64 and 8 months or over who are likely to become entitled to health insurance (Medicare) benefits upon attaining age 65, and individuals under age 65 who have at least 21 months of disability benefits who are likely to become entitled to Medicare upon the 25th month or entitlement to such benefits and those populations that are dually eligible for both Medicare and Medicaid (Title XIX of the Act). Additionally, this system will maintain information on Medicare beneficiaries Parts A, B, C, and D and physicians, providers, employer plans, Medicaid recipients and Medicare secondary payers.

CATEGORIES OF RECORDS IN THE SYSTEM:

Information maintained in the system include, but are not limited to: standard data for identification such as health insurance claim number, social security number, gender, race/ethnicity, date of birth, geographic location, Medicare enrollment and entitlement information, MSP data necessary for appropriate Medicare claim payment, hospice election, MA plan elections and enrollment, End Stage Renal Disease (ESRD) entitlement, historic and current listing of residences, and Medicare eligibility and Managed Care institutional status. Additionally, this system will maintain identifying information on physicians, providers,

employer plans, Medicaid recipients and Medicare secondary payers.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

Authority for the collection of data maintained in this system is given under §§ 226, 226A, 1811, 1818, 1818A, 1831, 1833(a) (1) (A), 1836, 1837, 1838, 1843, 1866, 1874a, 1875, 1876, 1881, and 1902(a) (6) of the Social Security Act (the Act). The following are the corresponding sections from Title 42 of the United States Code (U.S.C.): 426, 426-1, 1395c, 1395i-2, 1395i-2a, 1395j, 1395l(a)(1)(A), 1395o, 1395p, 1395q, 1395v, 1395cc, 1395kk-l, 1395ll, 1395mm, 1395rr, 1396a(a)(6), and § 101 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Public Law 108-173), which established the Medicare Part D program.

PURPOSE(S) OF THE SYSTEM:

The primary purpose of this system is to establish an enterprise resource that will provide one integrated view of all CMS data to administer the Medicare and Medicaid programs. Information retrieved from this system of records will also be disclosed to: (1) support regulatory, reimbursement, and policy functions performed within the agency or by a contractor, consultant or CMS grantee; (2) assist another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent; (3) support providers and suppliers of services for administration of Title XVIII; (4) assist third parties where the contact is expected to have information relating to the individual's capacity to manage his or her own affairs; (5) assist Medicare Advantage Plans and Part D Prescription Drug Plans; (6) support Quality Improvement Organizations (QIO); (7) assist other insurers for processing individual insurance claims; (8) facilitate research on the quality and effectiveness of care provided, as well as payment related projects; (9) support litigation involving the agency; and (10) combat fraud, waste, and abuse in certain health benefits programs.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OR USERS AND THE PURPOSES OF SUCH USES:

The Privacy Act allows us to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such compatible use of data is known as a "routine use." The proposed routine uses in this system meet the compatibility requirement of the Privacy Act. We are proposing to establish the following routine use disclosures of information maintained in the system:

1. To support agency contractors, consultants or grantees who have been engaged by the agency to assist in the performance of a service related to this system and who need to have access to the records in order to perform the activity.
2. To assist another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent to:
 - a. contribute to the accuracy of CMS' proper payment of Medicare benefits,
 - b. enable such agency to administer a Federal health benefits program, or as

- necessary to enable such agency to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds, and/or
- c. assist Federal/state Medicaid programs within the state.

3. To support providers and suppliers of services directly or through fiscal intermediaries or carriers for the administration of Title XVIII of the Act.
4. To assist third party contact in situations where the party to be contacted has, or is expected to have information relating to the individual's capacity to manage his or her affairs or to his or her eligibility for, or an entitlement to, benefits under the Medicare program and;
 - a. the individual is unable to provide the information being sought (an individual is considered to be unable to provide certain types of information when any of the following conditions exists: the individual is confined to a mental institution, a court of competent jurisdiction has appointed a guardian to manage the affairs of that individual, a court of competent jurisdiction has declared the individual to be mentally incompetent, or the individual's attending physician has certified that the individual is not sufficiently mentally competent to manage his or her own affairs or to provide the information being sought, the individual cannot read or write, cannot afford the cost of obtaining the information, a language barrier exist, or the custodian of the information will not, as a matter of policy, provide it to the individual), or
 - b. the data are needed to establish the validity of evidence or to verify the accuracy of information presented by the individual, and it concerns one or more of the following: the individual's entitlement to benefits under the Medicare program, the amount of reimbursement, and in cases in which the evidence is being reviewed as a result of suspected fraud, waste, and abuse, program integrity, quality appraisal, or evaluation and measurement of activities.
5. To assist Medicare Advantage Plans, Part D Prescription Drug Plans and their Prescription Drug Event submitters, providing protection against medical expenses of their enrollees without the beneficiary's authorization, and having knowledge of the occurrence of any event affecting (a) an individual's right to any such benefit or payment, or (b) the initial right to any such benefit or payment, for the purpose of coordination of benefits with the Medicare program and implementation of the Medicare Secondary Payer provision at 42 U.S.C. 1395y (b).

Information to be disclosed shall be limited to Medicare entitlement, enrollment and utilization data necessary to perform that specific function. In order to receive the information, they must agree to:

- a. certify that the individual about whom the information is being provided is one of its insured or employees, or is insured and/or employed by another entity for whom they serve as a Third Party Administrator;
- b. utilize the information solely for the purpose of processing the individual's

- enrollment or insurance claim; and
- c. safeguard the confidentiality of the data and prevent unauthorized access.

6. To support Quality Improvement Organizations (QIO) in connection with review of claims, or in connection with studies or other review activities conducted pursuant to Part B of Title XI of the Act, and in performing affirmative outreach activities to individuals for the purpose of establishing and maintaining their entitlement to Medicare benefits or health insurance plans. As established by the Part D Program, QIOs will conduct reviews of prescription drug events data, or in connection with studies or other review activities conducted pursuant to Part D of Title XVIII of the Act.
7. To assist other insurers, underwriters, third party administrators (TPAs), self-insurers, group health plans, employers, health maintenance organizations, health and welfare benefit funds, Federal agencies, a state or local government or political subdivision of either (when the organization has assumed the role of an insurer, underwriter, or third party administrator, or in the case of a state that assumes the liabilities of an insolvent insurers pool or fund), multiple-employers trusts, no-fault medical, automobile insurers, workers' compensation carriers plans, liability insurers, and other groups providing protection against medical expenses who are primary payers to Medicare in accordance with 42 U.S.C. 1395y(b), or any entity having knowledge of the occurrence of any event affecting;
 - a. an individual's right to any such benefit or payment, or
 - b. the initial or continued right to any such benefit or payment (for example, a State Medicaid Agency, State Workers' Compensation Board, or Department of Motor Vehicles) for the purpose of coordination of benefits with the Medicare program and implementation of the MSP provisions at 42 U.S.C. 1395 y(b). The information CMS may disclose will be:
 - Beneficiary Name
 - Beneficiary Address
 - Beneficiary Health Insurance Claim Number
 - Beneficiary Social Security Number
 - Beneficiary Gender
 - Beneficiary Date of Birth
 - Amount of Medicare Conditional Payment
 - Provider Name and Number
 - Physician Name and Number
 - Supplier Name and Number
 - Dates of Service
 - Nature of Service
 - Diagnosis

To administer the MSP provision at 42 U.S.C. 1395 y (b) (2), (3), and (4) more effectively, CMS would receive (to the extent that it is available) and may disclose the following types of information from insurers, underwriters, third party administrator, self-insurers, etc.:

- Subscriber Name and Address
- Subscriber Date of Birth
- Subscriber Social Security number
- Dependent Name
- Dependent Date of Birth
- Dependent Social Security Number
- Dependent Relationship to Subscriber
- Insurer/Underwriter/TPA Name and Address
- Insurer/Underwriter/TPA Group Number
- Insurer/Underwriter/Group Name
- Prescription Drug Coverage
- Policy Number
- Effective Date of Coverage
- Employer Name, Employer Identification Number (BIN) and Address
- Employment Status
- Amounts of Payment

To administer the MSP provision at 42 U.S.C. 1395y(b) (1) more effectively for entities such as Workers' Compensation carriers or boards, liability insurers, no-fault and automobile medical policies or plans, CMS would receive (to the extent that it is available) and may disclose the following information:

- Beneficiary's Name and Address
- Beneficiary's Date of Birth
- Beneficiary's Social Security number
- Name of Insured
- Insurer Name and Address
- Type of coverage; automobile medical, no-fault, liability payment, or workers' compensation settlement
- Insured's Policy Number
- Effective Date of Coverage
- Date of accident, injury or illness
- Amount of payment under liability, no-fault, or automobile medical policies, plans, and workers' compensation settlements
- Employer Name and Address (Workers' Compensation Only)
- Name of insured could be the driver of the car, a business, the beneficiary (i.e., the name of the individual or entity which carries the insurance policy or plan)

In order to receive this information the entity must agree to the following conditions; to utilize the information solely for the purpose of coordination of benefits with the Medicare program and other third party payer in accordance with Title 42 U.S.C. 1395 y (b);

to safeguard the confidentiality of the data and to prevent unauthorized access to it; and,
to prohibit the use of beneficiary-specific data for the purposes other than for the

coordination of benefits among third party payers and the Medicare program. This agreement would allow the entities to use the information to determine cases where they or other third party payers have primary responsibility for payment. Examples of prohibited uses would include but are not limited to; creation of a mailing list, sale or transfer of data.

To administer the MSP provisions more effectively, CMS may receive or disclose the following types of information from or to entities including insurers, underwriters, TPAs, and self-insured plans, concerning potentially affected individuals:

- Subscriber HICN
 - Dependent Name
 - Funding arrangements of employer group health plans, for example, contributory or non-contributory plan, self-insured, re-insured, HMO, TPA insurance
 - Claims payment information, for example, the amount paid, the date of payment, the name of the insurers or payer
 - Dates of employment including termination date, if appropriate
 - Number of full and/or part-time employees in the current and preceding calendar years
 - Employment status of subscriber, for example, full or part time or self-employed
8. To assist an individual or organization for a research project or in support of an evaluation project related to the prevention of disease or disability, the restoration or maintenance of health, or payment related projects.
9. To support the Department of Justice (DOJ), court or adjudicatory body when: the agency or any component thereof, or any employee of the agency in his or her official capacity, or any employee of the agency in his or her individual capacity where the DOJ has agreed to represent the employee, or the United States Government, is a party to litigation or has an interest in such litigation, and by careful review, CMS determines that the records are both relevant and necessary to the litigation and that the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which the agency collected the records.
10. To support a CMS contractor (including, but not necessarily limited to fiscal intermediaries and carriers) that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud, waste, or abuse in such program.
11. To support another Federal agency or to an instrumentality of any governmental

jurisdiction within or under the control of the United States (including any State or local governmental agency), that administers, or that has the authority to investigate potential fraud, waste, or abuse in, a health benefits program funded in whole or in part by Federal funds, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud, waste, or abuse in such programs.

E. Additional Provisions Affecting Routine Use Disclosures

To the extent this system contains Protected Health Information (PHI) as defined by HHS regulation "Standards for Privacy of Individually Identifiable Health Information" (45 CFR Parts 160 and 164, Subparts A and B) 65 Fed. Reg. 82462 (12-28-00), as modified at 67 Fed. Reg. 53,182 (8-14-2002). Disclosures of such PHI that are otherwise authorized by these routine uses may only be made if, and as, permitted or required by the "Standards for Privacy of Individually Identifiable Health Information."

In addition, our policy will be to prohibit release even of data not directly identifiable, except pursuant to one of the routine uses or if required by law, if we determine there is a possibility that an individual can be identified through implicit deduction based on small cell sizes (instances where the patient population is so small that, because of the small size, use this information to deduce the identity of the beneficiary).

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

All records are stored electronically.

RETRIEVABILITY:

All Medicare records are accessible by HICN, SSN, and unique provider identification number.

SAFEGUARDS:

CMS has safeguards in place for authorized users and monitors such users to ensure against unauthorized use. Personnel having access to the system have been trained in the Privacy Act and information security requirements. Employees who maintain records in this system are instructed not to release data until the intended recipient agrees to implement appropriate management, operational and technical safeguards sufficient to protect the confidentiality, integrity and availability of the information and information systems and to prevent unauthorized access.

This system will conform to all applicable Federal laws and regulations and Federal, HHS, and CMS policies and standards as they relate to information security and data privacy. These laws

and regulations may apply but are not limited to: the Privacy Act of 1974; the Federal Information Security Management Act of 2002; the Computer Fraud and Abuse Act of 1986; the Health Insurance Portability and Accountability Act of 1996; the E-Government Act of 2002, the Clinger-Cohen Act of 1996; the Medicare Modernization Act of 2003, and the corresponding implementing regulations. OMB Circular A-130, Management of Federal Resources, Appendix III, Security of Federal Automated Information Resources also applies. Federal, HHS, and CMS policies and standards include but are not limited to: all pertinent National Institute of Standards and Technology publications; the HHS Information Systems Program Handbook and the CMS Information Security Handbook.

RETENTION AND DISPOSAL:

Records are maintained for a period of 6 years and 3 months. All claims-related records are encompassed by the document preservation order and will be retained until notification is received from DOJ.

SYSTEM MANAGER AND ADDRESS:

Director, Division of Business Analysis & Analysis, Enterprise Databases Group, Office of Information Services, CMS, Room N1-14-08, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

NOTIFICATION PROCEDURE:

For purpose of access, the subject individual should write to the system manager who will require the system name, HICN, address, date of birth, and gender, and for verification purposes, the subject individual's name (woman's maiden name, if applicable), and SSN. Furnishing the SSN is voluntary, but it may make searching for a record easier and prevent delay.

RECORD ACCESS PROCEDURE:

For purpose of access, use the same procedures outlined in Notification Procedures above. Requestors should also specify the record contents being sought. (These procedures are in accordance with department regulation 45 CFR 5b.5 (a) (2)).

CONTESTING RECORDS PROCEDURES:

The subject individual should contact the system manager named above, and reasonably identify the records and specify the information to be contested. State the corrective action sought and the reasons for the correction with supporting justification. (These Procedures are in accordance with Department regulation 45 CFR 5b.7).

RECORDS SOURCE CATEGORIES:

The data collected and maintained in this system are retrieved from the following databases: Medicare Drug Data Processing System, System No. 09-70-0553 (70 *Federal Register* (Fed. Reg.) 58436 (October 6, 2005)); Medicare Beneficiary Database, System No. 09-70-0536 (71 Fed. Reg. 11425 (March 7, 2006)); Medicare Advantage Prescription Drug System, System No. 09-70-4001 (70 Fed. Reg. 60530 (October 18, 2005)); Medicaid Statistical Information System, System No. 09-70-0541 (71 Fed. Reg. 65527 (November 8, 2006)); Retiree Drug Subsidy Program, System No. 09-70-0550 (70 Fed. Reg. 41035 (July 15, 2005)); Common Working File, System No. 09-70-0526 (71 Fed. Reg. 64955 (November 6, 2006)); National Claims History, System No. 09-70-0005 (67 Fed. Reg. 57015 (September 6, 2002)); Enrollment Database, System No. 09-70-0502 (67 Fed. Reg. 3203 (January 23, 2002)); Multi-Carrier Claims System (formerly known as the Carrier Medicare Claims Record), System No. 09-70-0501 (71 Fed. Reg. 64968 (November 6, 2006)); Fiscal Intermediary Shared System (formerly known as the Intermediary Medicare Claims Record), System No. 09-70-0503 (71 Fed. Reg. 64961 (November 6, 2006)); Unique Physician/Provider Identification Number, System No. 09-70-0525, (69 Fed. Reg. 75316 (December 16, 2004)); Medicare Supplier Identification File, System No. 09-70-0530 (71 Fed. Reg. 65527 (November 8, 2006)). Information will also be provided from the application submitted by the individual through state Medicaid agencies, the Social Security Administration and through other entities assisting beneficiaries.

SYSTEMS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:

None.

Attachment E: WA Coordination of Benefits and Quality Improvement Approval

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-13-23
Baltimore, Maryland 21244-1850



Medicare-Medicaid Coordination Office

June 15, 2011

Beverly Court
Research Manager
Washington State Medicaid Purchasing Administration

Dear Ms. Court,

In accordance with Section IV, Paragraph (A)(4) of the Coordination of Benefits Agreement (COBA), we are in receipt of your proposal to utilize the Medicare Parts A & B claims data provided to the State of Washington under the COBA for quality improvement and care coordination activities and/or to re-release the data.

This letter hereby approves your proposal, which is attached, with the exception of sharing data with the Puget Sound Health Alliance.

Prior to receiving the data, the following items must be completed:

1. Your State will need to complete the "COBA Attachment" (http://www.cms.gov/COBAgreement/Downloads/COBAAttachment_V2.pdf) in which you will request a New Trading Partner/COBA ID within the range of 79000—79999 (i.e., Medicaid Quality COBA ID).
2. You will submit this completed and signed "COBA Attachment" via overnight mail to your State's Electronic Data Interchange (EDI) Representative at the COB Contractor (COBC). In this document you will specify exactly what data you wish to receive and how you wish to receive it. You will select which claims you would like to receive (e.g., hospital inpatient, skilled nursing facility, home health, etc.) and how often you would like to receive them. Your EDI Representative is:

Flona Scott
EDI Specialist - COB/Medicare
fscott@ehmedicare.com
phone: 646-447-2019

3. Your COBC EDI Representative will send a Profile Report back to you as a validation of your request.

1

Attachment E: WA Coordination of Benefits and Quality Improvement Approval

4. Please confirm the accuracy of your request by signing this signatory letter and sending it back to your COBC EDI Representative.
5. You will then send an eligibility file to the Coordination of Benefits Contractor (COBC).
6. The COBC will send an eligibility acknowledgement and response file back to you, as you normally receive under the COBA crossover process.

Your State and all downstream users are strictly prohibited from the using the Medicare Parts A & B claims data for any purposes that are not specified in the attached proposal or that are not otherwise permitted under the Coordination of Benefits Agreement.

Sincerely,



Sharon Donovan
Director, Program Alignment Group
Medicare-Medicaid Coordination Office

Enclosures

cc Karyn Kai Anderson

Attachment E: WA Coordination of Benefits and Quality Improvement Approval



STATE OF WASHINGTON DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Medicaid Purchasing Administration
626 8th Avenue, S.E. • P.O. Box 45502
Olympia, Washington 98504-5502

May 24, 2011

Karyn Kal Anderson, PhD, MPH
Federal Coordinated Health Care Office
Centers for Medicare & Medicaid Services
7500 Security Blvd., Mailstop C3-20-17
Baltimore MD 21244-1850

RE: Washington State Business Needs, Medicare Part A and B
Medicaid Dual-Eligible Data for Quality Improvement

Dear Dr. Anderson:

Washington State is requesting a revised Coordination of Benefits Agreement (COBA) to receive Medicare Part A and B claims for Medicare/Medicaid dual eligible clients. This request replaces our requests dated February 7, 2011, March 1, 2011, and March 21, 2011 in response to your questions posed May 23, 2011.

I. Washington State seeks permission from CMS to use the COBA claims data for care coordination and other quality improvement activities that fall within paragraphs (1) and (2) of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule definition of Health Care Operations or Treatment. (45 CFR Section 164.501.)

A. Use of the Data

1. Treatment

Activity	HIPPA Treatment Purposes
Care Coordination through development of comprehensive individual client profiles, integrating risk indicators as detailed above and all available sources of claims and encounter data (physical health, behavioral health, long term care), eligibility data, patient assessments, and care manager notes on the individual for the past 15 months, in a web-based clinical decision-support tool referred to as PRISM (Predictive Risk Intelligence System).	-the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; - consultation between health care providers relating to a patient; - the referral of a patient for health care from one health care provider to another
<i>Example: List of filled prescriptions in past 15 months, from all sources, fee-for-service and managed care, can be provided to primary care provider by care coordinator at office visit for treatment purposes.</i>	

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Activity	HIPPA Treatment Purposes
Disease management reports - for health care provider follow-up <i>Examples: Prescription opioid use, disease-specific and psychotropic medication adherence, respiratory/cardiac/diabetes management and other topics as identified by the state Medicaid Medical Director.</i>	<ul style="list-style-type: none"> -the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; - consultation between health care providers relating to a patient; - the referral of a patient for health care from one health care provider to another

2. Health Care Operations

Activity	HIPAA Health Care Operations
<p>Development of predictive risk indicators for care coordination and population management. Requires 5 years of historic claims data for sound predictive modeling (see B below).</p> <p>The primary purpose is not obtaining of generalizable knowledge, but to most accurately identify the level of care coordination and management needed for the individual, the specific interventions most likely to benefit the individual, and assess care coordination outcomes.</p> <p><i>Risk indicator examples include: Expected level of future medical expenditures; hospital readmission propensity; likelihood of outpatient emergency department use; risk of admission to a nursing home; likelihood of death within a given period; and likelihood of homelessness</i></p>	<ul style="list-style-type: none"> - Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines - Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, - Evaluating practitioner and provider performance, health plan performance
<p>Development of population profiles - Profiling of utilization, costs, outcomes and access of the dual population for care coordination program development and modeling of quality and performance incentive alternatives.</p> <p><i>Example: Implementation of 2703 health home and care coordination programs requires inclusion of dual eligible populations.</i></p>	<ul style="list-style-type: none"> - Population-based activities relating to improving health or reducing health care costs, case management and care coordination
<p>Outcomes evaluation of programs, including provider and client surveys. Required for monitoring of contracts including care coordination activities.</p>	<ul style="list-style-type: none"> - Conducting quality assessment and improvement activities, including outcomes evaluation
<p>Population-based quality studies to track process and outcomes in disease management areas, as well as development of clinical guidelines and other protocols for effective patient management. Includes targeted identification and contacting of health care providers and patients with information about treatment alternatives.</p>	<ul style="list-style-type: none"> - Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines - Population-based activities relating to improving health or reducing

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Activity	HIPAA Health Care Operations
<i>Examples: Prescription opioid use, disease-specific and psychotropic medication adherence, respiratory/cardiac/diabetes management and other topics as identified by the state Medicaid Medical Director.</i>	health care costs, protocol development, case management and care coordination
Development of performance measures and standards/targets for evaluation of practitioner, provider and health plan performance. Required for monitoring of contracts including care coordination activities. <i>Example: Puget Sound Health Alliance (regional collaborative of commercial health plans and Medicaid, participating in Robert Wood Johnson Foundation's Aligning Forces for Quality Initiative). Provides feedback to medical groups and health plans on their group performance and improvement on HEDIS and other measures including: access to care; appropriate use of care; asthma; depression; diabetes; generic prescription drugs; heart disease and prevention http://www.pugetsoundhealthalliance.org/ PCPs can also view their patients requiring care follow-up through secured website for care follow-up</i>	<ul style="list-style-type: none"> - Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines - Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, - Evaluating practitioner and provider performance, health plan performance - Reviewing the competence or qualifications of health care professionals, - accreditation, certification, licensing, or credentialing activities.

COBA claims will NOT be used for health care operations as detailed in 45 CFR Section 164.501(3)-(5): actuary work (underwriting, premium rating, reinsurance); conducting fraud and abuse activities (medical review, legal services or auditing functions); and entity business planning, development or management.

B. Justification for Request of 5 Years of Historic Part A and B Claims

In Washington State, the centerpiece of our quality improvement initiative is the development of care management interventions targeted to high-risk dual eligibles, because the potential beneficial impacts on health status and medical costs are likely to be greater for high-risk patients than for the general population of dually eligible clients. High-risk dual eligibles will be identified through the use of the PRISM predictive modeling tool.

At the heart of the PRISM predictive model is a hybrid version of the Chronic Illness and Disability Payment System and Medicaid-Rx risk models developed by Rick Kronick and Todd Gilmer at the University of California at San Diego. The PRISM predictive modeling tool will need to be recalibrated to dual eligible populations using pooled Medicare and Medicaid health services data, and may be augmented with long-term care assessment data that may be particularly predictive for dual eligible populations. Furthermore, within the dual eligible population it is likely that the predictive modeling risk weights for aged duals and disabled duals will be different. For example, an important risk factor is the receipt of antipsychotic medication. Among disabled duals, receipt of this medication is likely to indicate the presence of schizophrenia or other serious mental illness. Among the elderly, receipt of these medications is more likely to indicate dementia. Thus, "receipt of antipsychotic medication" will tend to signal different underlying disease conditions for disabled duals compared to elderly duals, and will have a different empirical relationship to the critical outcomes of interest (for example, risk of entry into a skilled nursing facility).

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Five years of Part A, B and D claims history will be necessary to implement and test the accuracy of predictive models to support care management for high-risk dual eligible patients. Predictive models designed to measure prospective risk are generally calibrated using two years of data for each observation for an individual person:

- A "base" year used to identify the person's risk factors from diagnosis, pharmacy and assessment data; and
- An "outcome" year to measure future outcomes including high medical costs, inpatient hospital admissions, excessive emergency department use, or skilled nursing facility entry.

For fitting the PRISM predictive model to existing non-dual Medicaid-only populations, we generally require in excess of 100,000 base-year/outcome-year observations to ensure adequate sample size to estimate the relationship between relatively rare risk factors (e.g., HIV/AIDS, heart transplant or hemophilia) and subsequent patient outcomes. In order to achieve the 100,000 observation threshold for both aged duals and disabled duals, with a minimum 6 months of dual enrollment in both the base and outcome years, we require 3 base-year/outcome-year pairs. These partially overlapping pairs of years span a period of 4 total years (e.g., from CY 2006/2007 to CY 2008/2009). Furthermore, it is highly desirable to have a fourth base-year/outcome-year pair to test the predictive accuracy of the predictive models outside of the time period used for model fitting. These four overlapping base-year/outcome-year pairs would span 5 calendar years (e.g., from CY 2006/2007 to CY 2009/2010). If you have further questions about our need for 5 years of claims data, or details on development of risk factors, contact David Mancuso, Senior Research Supervisor at david.mancuso@dshs.wa.gov.

C. Privacy and Security Measures to Protect Data

Washington requires a signed Business Associate Agreement for use of COBA claims data. The data security requirements (available upon request) cover: 1) Protection of data (hard disk drives, network server disks, optical discs in local workstation optical disc drives, optical discs in drive or jukeboxes attached to servers, paper documents, access via remote terminal/workstation of the State Governmental Network, access via remote terminal/workstation over the Internet through Secure Access Washington, data storage on portable devices or media); 2) Data segregation; 3) Data disposition; 4) Notice of compromise or potential compromise; 5) Data shared with sub-contractors. All receivers of personally identifiable health information must annually signed a Non-disclosure of DSHS Confidential Information form attesting to understanding of confidentiality and security requirements.

D. Sharing Results and Promising Practices with CMS

Washington was awarded a State Demonstration to Integrate Care for Dual Eligible Individuals grant in April 2011. The funding will allow for a thoughtful planning process to integrate dual eligibles into our care management, managed care and health home initiatives. The resulting plan will be shared with CMS, as well as program monitoring and evaluation reports as required under State Plan Amendments. Washington staff actively participate in dissemination of findings through groups including the Center for Health Care Strategies and the Medicaid Medical Directors Learning Network. Washington state staff would be happy to present results and promising practices with CMS and other states upon request.

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II. Washington State seeks permission from CMS to re-release the COBA claims data for care coordination and other quality improvement /treatment activities.

A. Re-Use of Data

Intended Recipients	HIPAA Status	Purpose	Mechanism
1. Care Management Pilot projects	1. Medicaid agency subcontractor with signed Business Associate Agreement (BA)	TREATMENT - Care Management To provide organized claims, eligibility, provider and demographic information organized around the client's expected diagnostic risk factors to assist in the development of person-centered plans of care and support.	1.) Clinical Decision Support Tool for Care Coordination (PRISM) - Via a secure web-based clinical decision support tool to look up individual clients. Providers can only see those clients they are contractually obligated to provide care coordination for. Refreshed at least monthly. 2.) Reports transmitted via secured e-mail or secured website
2. Medicaid Managed Care Organizations	2. Covered entity. Signed contract with Medicaid agency covers privacy and data security requirements.		
3. Area Agencies on Aging providing care management	3. Medicaid agency subcontractor with signed BA		
4. Managed Mental Health Care Organizations (Regional Support Networks)	4. Covered entity. Signed contract with Medicaid agency covers privacy and data security requirements.		
1. Medicaid Managed Care Organizations	1. Covered entity. Signed contract covers privacy and data security requirements.	TREATMENT - Disease Management and Quality Feedback Reports - To provide client-specific feedback to providers on clients requiring follow-up for prescription opioid use, disease-specific and psychotropic medication adherence, respiratory/cardiac/diabetes management and other topics as identified by the state Medicaid Medical Director	Reports transmitted via secured e-mail or secured website (Secure Access Washington)
2. Health care providers	2. Medicaid agency health care providers with signed BAs		
1. Milliman (actuarial firm) for the Puget Sound Health Alliance (regional collaborative of commercial health plans and Medicaid, participating in Robert Wood	1. Milliman is Medicaid agency subcontractor with signed BA; de-identified data supplied to Puget Sound Health Alliance, also a Medicaid agency subcontractor	HEALTH CARE OPERATIONS- Comparative Quality Performance Measurement To provide feedback to medical groups and health plans on their group performance and improvement on HEDIS and other measures including: access to care;	Claims are provided to a secured third party administrator (Milliman) through a secured website; the administrator determines primary care provider and produces aggregate measures. PCPs can view their clients

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Intended Recipients	HIPAA Status	Purpose	Mechanism
Johnson Foundation's Aligning Forces for Quality Initiative)	for quality improvement; Millman has signed BAs with health care providers	appropriate use of care; asthma; depression; diabetes; generic prescription drugs; heart disease and prevention	through secured website for care follow-up
1. External Quality Review Organizations/Quality Improvement Organizations (Including Acumentra Health, Qualis); 2. External evaluators (Including University of Washington; DSHS Research and Data Analysis Division)	1. Medicaid agency subcontractor with signed BA 2. Medicaid agency subcontractor with signed BA	HEALTH CARE OPERATIONS- Evaluation / Performance measure assessment and validation - To conduct federally required and agency program evaluation and performance monitoring including client surveys, HEDIS measurement / validation, and attainment of quality, cost, access or utilization goals. Results form the basis of quality improvement plans.	Claims are provided to external review and evaluation organizations via secured e-mail or secured website. Results are aggregated when shared publicly.

B. Privacy and Security Measures to Protect Re-released Data

Washington requires a signed contract for re-release of COBA claims data. The data security requirements (available upon request) cover: 1) Protection of data (hard disk drives, network server disks, optical discs in local workstation optical disc drives, optical discs in drive or jukeboxes attached to servers, paper documents, access via remote terminal/workstation of the State Governmental Network, access via remote terminal/workstation over the Internet through Secure Access Washington, data storage on portable devices or media); 2) Data segregation; 3) Data disposition; 4) Notice of compromise or potential compromise; 5) Data shared with sub-contractors. All receivers of personally identifiable health information must annually signed a Non-disclosure of DSHS Confidential Information form attesting to understanding of confidentiality and security requirements.

C. Monitoring Impact of Data Sharing /Sharing Results with CMS

The impact of sharing client data for care management purposes and for evaluation/measurement validation is monitored through annual program evaluation and annual contract management monitoring. Results are posted on-line at <http://hrsa.dshs.wa.gov/Reports/index.shtml>. Results form the basis of quality improvement plans. Comparative performance measurement is tracked over time to identify trends, though at this point with Medicaid-only data we are still working on refinement of data extraction and aggregation methodology. Aggregated results are posted at <http://www.wacomunitycheckup.org/>. Providers receiving feedback reports are queried to assure that the feedback reports are of value to the treatment of clients. Washington staff actively participate in dissemination of findings through groups including the Center for Health Care Strategies and the Medicaid Medical Directors Learning Network. Washington state staff would be happy to present results and promising practices with CMS and other states upon request.

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III. Storage of Cross-Over and Non-Cross-Over Claims

As required, crossover claims we currently receive for purposes of payment liability are received and maintained within the State's Medicaid Management Information System (MMIS). Crossover and non-crossover claims used for the purposes described above will be stored separately. Through this amendment to the COBA we will establish a separate Trading Partner COBA ID, develop new processes for exchanging eligibility data as required, and establish a separate secure FTP interface and claims data repository.

We look forward to working with you on acceptable uses of Medicare Part A and B data for our jointly administered Medicaid dual-eligible population. Please contact Beverly Court (beverly.court@dshs.wa.gov or 360-725-1643) with questions or to arrange further discussion.

Sincerely,



Cathie Ott, Deputy Chief Information Officer
Health Care Authority and Medicaid Purchasing Administration

VIA EMAIL through Bev Court

Cc: Bev Court
Luke Beals
Chandra Moss
Kevin Grover
David Akin